Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Kansas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Kansas Physical Disability Waiver

C. Waiver Number:KS.0304
Original Base Waiver Number: KS.0304.

D. Amendment Number:KS.0304.R05.01

E. Proposed Effective Date: (mm/dd/yy)
07/01/21

Approved Effective Date of Waiver being Amended: 01/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The Kansas State Legislature approved an increase to the Protected Income Level to 300% of Supplemental Security Income. This amendment is to allow for waiver participants to gain access to the new Protected Income Level. The state sees no adverse effects to waiver participants.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration	

Component of the Approved Waiver and Operation	Subsection(s)
☒ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☒ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Kansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Kansas Physical Disability Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: KS.0304
Waiver Number:KS.0304.R05.01
Draft ID: KS.014.05.02

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/20
Approved Effective Date of Waiver being Amended: 01/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

- (●) **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
  If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

  Not applicable

- ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- ( ) **Not applicable**
- (●) **Applicable**
  Check the applicable authority or authorities:
  - ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
  - ☐ **Waiver(s) authorized under §1915(b) of the Act.**
    Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

    Specify the §1915(b) authorities under which this program operates *(check each that applies):*
    - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
    - ☐ **§1915(b)(2) (central broker)**
    - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
    - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
  - ☐ **A program operated under §1932(a) of the Act.**
    Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
  - ☐ **A program authorized under §1915(i) of the Act.**
  - ☐ **A program authorized under §1915(j) of the Act.**
  - ☒ **A program authorized under §1115 of the Act.**
    Specify the program:

    KanCare 1115 Demonstration Project

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Kansas Physical Disability (PD) waiver is to provide eligible Kansans the option to receive services in their home and community rather than in a more expensive, less-integrated nursing home setting. PD services are available to individuals who are between 16 and 64 years of age, have a documented physical disability as determined by the Social Security Disability Administration, who meet the level of care for Nursing Facility admission, and who are financially eligible for Medicaid.

The State contracts with Aging and Disability Resource Centers (ADRC) to conduct the initial and annual functional eligibility assessments as well as performing information and referrals. Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community Based Services (HCBS) services as one part of the comprehensive KanCare program.

Services available through the PD waiver are: Assistive Services, Enhanced Care Services, Financial Management Services, Home-Delivered Meals, Medication Reminder Services and Installation, Personal Care Services, and Personal Emergency Response System and Installation.

The state offers agency directed options for all PD waiver services. There are opportunities for waiver participants to self-direct certain services within the PD waiver.

Entry into the waiver is based on a first-come, first-served basis for participants determined eligible. In the event there is a waiting list, entry is based on the date the functional assessment is completed. Responsibility for managing the waitlist remains with KDADS.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

A public notice was not required as this is not a substantive change. The Tribal Notice was posted June 10, 2021 and ended June 24, 2021. The Tribal Notice did not elicit any comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Graff-Hendrixson

First Name: Bobbie

Title: Director of Compliance and Contracting

Agency: Kansas Department of Health and Environment

Address: Landon State Office Building, Room 900N

Address 2: 900 SW Jackson Street

City: Topeka

State: **Kansas**

Zip: 66612-1220

Phone: (785) 296-0149 **Ext:** ☐ **TTY**

Fax: (785) 296-4813

E-mail: Bobbie.Graff-Hendrixson@ks.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Cintron

First Name: Christopher

Title: PD Program Manager

Agency: Kansas Department for Aging and Disability Services/Community Services & Programs

Address: New England Building

Address 2: 503 S. Kansas Avenue

City: Topeka

State: **Kansas**

Zip: 66612-1570

Phone: (785) 296-1708 **Ext:** ☐ **TTY**

Fax: (785) 296-0557

E-mail: christopher.cintron@ks.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Kurt Weiter

State Medicaid Director or Designee

Submission Date: Jun 25, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: weiter

First Name: kurt

Title: Waiver Program Manager

Agency: KDHE

Address: 900 SW Jackson Avenue, Suite 900 N

Address 2:

City:

Topeka

State: **Kansas**

Zip: 66612

Phone: (785) 296-8623 **Ext:** ☐ **TTY**

Fax: (785) 296-4813

E-mail: kurtjoseph65@gmail.com

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☒ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The State does not anticipate any impact on waiver participants, the decrease to Factor C is not restricting eligibility, but instead is a technical adjustment to reflect actual utilization patterns.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

"The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Kansas Department for Aging and Disability Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
- Information received from CMS;
- Proposed policy changes;
- Waiver amendments and changes;
- Data collected through the quality review process;
- Eligibility, numbers of participants being served;
- Fiscal projections; and
- Any other topics related to the waivers and Medicaid

b. All policy changes related to the waivers are approved by KDHE.

c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.

d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the programs, in collaboration with the operating agency, and the KanCare MCO contracts, including those items identified in part (a) above. The key component of that collaboration be through the interagency monitoring, an important part of the overall state's KanCare Quality Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state's KanCare Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) is guided by the KanCare Quality Strategy. A critical component of that strategy is the engagement of the interagency monitoring, which bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including interagency monitoring meetings – occur on a quarterly basis. While

continuous monitoring is conducted, including monthly and other intervals, the aggregation, analysis and trending processes is built around that quarterly structure.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

KDADS contracts with the Aging and Disability Resource Centers (ADRC) to receiving referrals, provide options counseling, complete the standard intake and conduct the functional eligibility assessment for the PD waiver.

The MCOs, or their designee, conduct a comprehensive needs assessment, develop the Person-Centered Service Plan (which includes both waiver and state plan services), assist the participant in developing the Participant Interest Inventory (PII), offer provider choice, offer choice between self or agency direction, conduct provider credentialing, conduct provider training, monitor of service delivery and participate in the comprehensive state quality improvement strategy for the KanCare program.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

The Aging and Disability Resource Centers (ADRC) are contracted by KDADS to provide Health and Community Based Services (HCBS) assessments to individuals wanting to obtain waiver services through the Physical Disability (PD) waiver. The ADRC performs the assessment and the state system determines the Level of Care score. The ADRC does not make the determination, the data is provided to the state to be calculated by the state MIS. The scores are then calculated by the state to determine level of care (LOC) eligibility. In addition to assessing individuals for HCBS waivers, the ADRC's also provide Options Counseling to individuals to educate them on services available within their community. The ADRC's also operate a call-center that provides information, referrals, and assistance to individuals statewide.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Kansas Department for Aging and Disability Services.

KDHE completes oversight of KDADS through monthly Long -Term Care meetings in which KDADS submits reports to KDHE regarding LOC eligibility determinations.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Contracted entities, including both contracted entities/providers and the state's contracted MCOs, are monitored through the HCBS Quality Strategy (appendix H). All functions delegated to contracted entities are included in the HCBS quality review processes. A key component of that monitoring and review process is collaboration between KDHE and KDADS which includes HCBS waiver management staff from the Kansas Department for Aging and Disability Services (KDADS). In addition, the SSMA and the State Operating Agency will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will include oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors.

The HCBS Quality Strategy ensures that the entities contracting with KDADS are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1115 waiver, Kansas statutes and regulations, and related policies.

KDHE monitors KDADS' development of operational processes and collaborates with KDADS to ensure that appropriate administrative oversight components are specified in those processes. Through existing KDHE policy review processes and monthly KDHE Long Term Care (LTC) meeting updates/reports, KDHE ensures implementation of the operational processes.

Oversight of the ADRCs and the MCOs is conducted on a quarterly basis via the KDADS Quality Review process. In instances where KDADS is primarily responsible for conducting the quality review, KDADS analyzes and compiles the performance results and reports the findings and summaries to the Medicaid agency.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than*

one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☐	☐
Level of care evaluation	☒	☒	☒	☒
Review of Participant service plans	☒	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒	☒
Utilization management	☒	☒	☒	☒
Qualified provider enrollment	☒	☒	☒	☒
Execution of Medicaid provider agreements	☒	☐	☐	☐
Establishment of a statewide rate methodology	☒	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☒	☒
Quality assurance and quality improvement activities	☒	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and Percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracked by Program Manager

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the state Medicaid Agency D=Number of Quality Review reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracked by Program Manager

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency N=Number of waiver amendments and renewals and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracked by Program Manager

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D= Number of waiver policy changes implemented by the Operation Agency

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Review Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Quality Management Specialists during the Quality Survey process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. The Managed Care Organizations are engaged with state staff to ensure a strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

KDHE and KDADS have a standing weekly policy meeting to review all KDADS and KDHE policies prior to finalization and public posting. KDHE assigns policy numbers to all final KDADS' policies. No policy may be assigned a policy number without being reviewed and approved by KDHE at the weekly meeting.

KDADS Quality Management Staff have a standing schedule and timeline by which reviews must be completed and a report generated. The results of the quality reviews are submitted to the KDHE and KDADS Long Term Care meeting for review. Any issues with the reports are discussed and follow up action assigned during those meetings. In addition, KDADS Quality Staff and HCBS Program Staff meet monthly to discuss findings from the quality reviews and any process changes that are needed.

The HCBS Director is responsible for ensuring attendance of HCBS Program Managers at the monthly Long-Term Care meetings. Any disciplinary action needed is handled by the HCBS Director.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more

groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	16	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Participants who are approaching their 65th birthday have a choice of remaining on the PD waiver or transitioning to the Frail Elderly (FE) waiver provided they meet established eligibility criteria.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

KanCare MCOs consult with participants to discuss differences in waiver services between the FE and PD waivers and determine the participants' choice on which waiver they would like to be served by. The process for transitions from the PD waiver to the FE waiver is established in the HCBS Physical Disability Transition policy.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ( ) **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	6898
Year 2	6898
Year 3	6898
Year 4	6898
Year 5	6898

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	6147
Year 2	6147
Year 3	6147
Year 4	6147
Year 5	6147

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
PD Participants in the Custody of DCF	
Temporary Institutional Stay	
WORK Program	
HCBS Institutional Transitions	
Military Inclusion	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

PD Participants in the Custody of DCF

Purpose *(describe):*

The State reserves capacity for PD waiver participants age 16-19 years who are in the custody of DCF in accordance with the HCBS Access for individuals in the custody of DCF policy.

Describe how the amount of reserved capacity was determined:

The number of reserved capacity is based on actual PD waitlist data.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Temporary Institutional Stay

Purpose *(describe):*

The state reserves capacity to maintain continued waiver eligibility for participants who enters into an institution such as hospitals, ICF/ID or nursing facilities for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services at a later date and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.

Describe how the amount of reserved capacity was determined:

Historical information data are used to determine slots. Individuals already on waiver services can access temporary institutional care, while those not on waiver services goes through the institutional transition process.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved	
Year 1	150	
Year 2	150	
Year 3	150	
Year 4	150	
Year 5	150	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

WORK Program

Purpose *(describe):*

The State reserves capacity for PD program participants who have participated in the WORK program have the option to return to the program and bypass the wait list if the program maintains a waitlist. Consistent with CMS required annual eligibility re-determination participants must be reassessed within 90 days of leaving the WORK program in accordance with program eligibility level of care requirements. If the consumer is determined to not meet level of care eligibility, KDADS will terminate services using established process, including appeal rights

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined using actual number of past participants who transition back to the PD waiver from the WORK program.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved	
Year 1	5	
Year 2	5	
Year 3	5	
Year 4	5	
Year 5	5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

HCBS Institutional Transitions

Purpose *(describe):*

The State reserves capacity for individuals transitioning from an approved institutional setting to the PD waiver in accordance with the HCBS Institutional Transition Policy.

Describe how the amount of reserved capacity was determined:

Institutional transition reserve capacity is based on historical data that show the number of people who have chosen to transition from an approved institutional setting to the PD waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	110
Year 2	110
Year 3	110
Year 4	110
Year 5	110

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Military Inclusion

Purpose *(describe):*

The State reserves capacity for military participants and their immediate dependent family members who have been determined program eligible may bypass waitlist upon approval by KDADS. Individuals who have been determined to meet the established PD waiver criteria will be allowed to bypass the waitlist and access services.

Describe how the amount of reserved capacity was determined:

Slots are determined through an analysis of military personnel accessing this waiver service and there are no data to support projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

1. PD waiver eligibility criteria is defined in the HCBS Physical Disability Eligibility policy.
2. The waitlist process and procedures are identified in the HCBS Physical Disability Eligibility policy.
3. The process and procedures for applying for a crisis exception to the PD waiting list are identified in the HCBS Physical Disability Crisis Exception policy.
4. The HCBS Institutional Transition policy identifies the process and procedures for allowing eligible individuals discharging from an approved institutional setting to bypass the PD waitlist and access the waiver.
5. The Military Inclusion policy identifies the process and procedures for eligibility military participants and their immediate dependent family members (as defined by IRS) to bypass the PD waitlist and access waiver services.
6. The KDADS WORK Transition policy details the process for individuals to access the waiver from the WORK program.
7. The process to transition from the BI waiver to the PD waiver is specified in the TBI Transition policy.

Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. The PD waiver has a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the waiting list remains with the State (KDADS).
Participants may supersede the waiting list process if they fall into one of the following groups:
- Children under DCF custody
- Participants transferring directly from another HCBS waiver such as Technology Assistance (TA) and Brain Injury (BI).
- Participants exiting a Medicaid approved nursing facility through the HCBS Institutional Transition Policy.
- The reserve capacity groups other than children in DCF custody, people receiving a crisis exception, and people who are transferring from the WORK program.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

  Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

  Parents and other caretaker relatives (42 CFR 435.110)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☒ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility

for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: ☐

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:
- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ◉ **Other**

  Specify:

  300% of SSI

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

The Aging and Disability Resource Centers (ADRC) contract with the State and are responsible for performing the evaluation and reevaluation for level of care determination as indicated in appendix A of this application. The ADRC performs the assessment and the state system determines the Level of Care score. The ADRC does not make the determination, the data is provided to the state to be calculated by the state MIS.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualifications of ADRC functional eligibility assessor:

Four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the ADRC contractor; or a Registered Nurse license to practice in the state of Kansas. The ADRC is responsible for verifying assessor experience, education and certification requirements are met for assessors. The contractor must maintain these records for five (5) years following termination of employment.

Functional eligibility assessors must attend initial certification and recertification training sessions according to KDADS' Policy. Functional eligibility assessors must successfully complete FEI and Kansas Aging Management Information System (KAMIS) training prior to performing any functional eligibility assessment.

A functional eligibility assessor that has not conducted any functional assessments within the last six months must repeat the training and certification requirements for the FEI.

KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all FEI assessors. KDADS shall provide training materials and written documentation of successful completion of training. Assessors must participate in all state-mandated trainings to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by KDADS. Tracking staff training is the responsibility of the contractor and should be recorded in the manner required by KDADS.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Participants with a physical disability must meet the level of care required for Medicaid Nursing Facility placement. See Appendix B-1 for the functional and programmatic eligibility criteria for the PD waiver.
The level of care is determined by utilizing the functional eligibility instrument (FEI). The FEI is an assessment of an individual's capacity to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and measures an individual's and cognitive limitations that will be critical to the development of a participant's Person-Centered Service Plan.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The ADRC shall perform conflict free functional eligibility assessments. The level of care criteria utilized for initial assessments of PD waiver participants and yearly reassessments of waiver participants is the same. Participants must meet the Medicaid Long Term Care threshold score based on an assessment completed with the functional eligibility instrument (FEI). The contracted assessors will screen for reasonable indicators of meeting the level of care eligibility prior to administering the functional eligibility instrument. The level of care assessment and reassessment process is conducted by a qualified assessor contracted with Kansas.

Information used to determine scores and other eligibility criteria can come from a variety of sources. The participant is the primary source of information. The assessing entity uses interview techniques that are considerate of any limitations the participant might have with hearing, eyesight, cognition, etc. Family members and other individuals who might have relevant information about the participant can also be interviewed. The contracted assessors may also use clinical records, if available, and/or discuss the participant's status with the appropriate medical professional when authorized by the participant.

All community referrals may contact the assessing entity directly and they will intake pertinent referral information and conduct preliminary screening for reasonable indicators of meeting the program level of care criteria. In the event a participant has a primary diagnosis of I/DD, the assessor must make a referral to the CDDO, in the area which the participant resides, for evaluation.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Timely re-evaluation requirements are also included in the State's contract with the ADRC. Assurance that timely re-evaluations are conducted are monitored through the KDADS quarterly quality review process. In the event the contractor does not meet the requirements, KDADS issues a corrective action plan which requires the contractor to detail their remediation strategy to come into compliance. The ADRC receives a monthly reassessment report from KDADS with a list of all waiver participants that have assessments expiring within 30 days.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and/or electronically retrievable documentation of all evaluations and reevaluations is maintained by the State. The ADRC uploads the documentation into the KDADS data base that houses all documentation related to functional assessments.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample**

		Confidence Interval = 95% +/-5%
☒ **Other** Specify: Contracted assessors and Managed Care Organizations (MCOs)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating agency's data system: "Kansas Assessment Management Information (KAMIS)System or its related web applications"

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: Contracted assessors	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of

initial Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: Contracted assessors	☐ **Annually**	☒ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate by MCO
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor N=Number of initial Level Of Care (LOC)determinations made by a qualified assessor D=Number of initial Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Assessor and assessment records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted Assessor	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: Record reviews	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Contracted assessors participate in analysis of this measure's results as determined by the State operating agency.	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures are a part of the HCBS quality strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of the functional eligibility contractors with Kansas will be monitored on an ongoing basis to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through the quality review process. These processes are monitored by both program managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the HCBS quality strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Before the functional eligibility evaluation is conducted, as a part of the referral process the ADRC educates the individual on their choices of community-based programs as well as the institutional equivalent. The ADRC assessor documents the individuals' choice of Home and Community-based services on the eligibility communication form (E-3160) used by the state. In addition, during the Person-Centered Service Plan development process, the KanCare MCO selected by the participant informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the PD Waiver Participant Choice Form.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

PD Waiver Participant Choice forms are documented and maintained in the participant’s file by the functional eligibility assessor and the participant's chosen KanCare MCO.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. To comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information. This information is captured in the Functional Eligibility Instrument (FEI).

The State of Kansas defines prevalent non- English languages as languages spoken by significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that particiapnts may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the participant in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the consumer in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contract with KDADS and available statewide.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Personal Care Services**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Assistive Services**		
Other Service	**Enhanced Care Service**		
Other Service	**Home-Delivered Meals Service**		
Other Service	**Medication Reminder Services**		
Other Service	**Personal Emergency Response System and Installation**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Personal Care Services (PCS) includes supports for the participant in the following areas:
1. Activities of Daily Living (ADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy.
2. Health maintenance activities (HMA) in accordance with the Personal Care Services and Limitations policy.
3. Instrumental Activities of Daily Living (IADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy
4. Assistance and accompaniment for exercise, socialization and recreation activities
5. Assistance accessing medical care

PCS are individualized (one-to-one) services provided during times when the participant is not typically sleeping. The cost associated with the provider travelling to deliver this service is included in the rate paid to the provider. Non-emergency Medical Transportation (NEMT) is a State Plan service and can be accessed through the MCO.

The service must occur in a home or community location meeting the setting requirements as defined in the “HCBS Setting Final Rule.” Home is where the participant makes his or her residence and must not be defined as institutional in nature. A family is defined as any person immediately related to the participant, such as: parents/legal guardian, spouse, siblings; or when the participant lives with other persons capable of providing the care as a part of the informal support system.

Informal/natural supports may include relatives and friends that live with the waiver participant. An informal/natural support, who is capable of providing assistance with IADL tasks, may not be paid to perform these tasks when they can be completed in conjunction with normal household duties. If a capable, informal/natural support refuses or is unable to provide assistance with the IADL tasks, the refusal or inability must be documented in writing, signed by the informal/natural support and included in the Service Plan. In these instances, the MCO may authorize the individual to receive self-directed or agency-directed formal support for the authorized IADL tasks. The individual may choose to self-direct; however, the self-directed worker may not be the capable, informal/natural support who has refused or is incapable of performing assistance with the IADLs as a part of normal household duties. Unless there are extenuating or specific circumstances that are documented in the Service Plan, waiver participants should rely on informal/natural supports who are capable and willing to provide assistance with IADLs when they can be completed in conjunction with normal household duties. The IADL tasks that can be completed in conjunction with normal household duties include: lawn care, snow removal, shopping, housekeeping, laundry, and meal preparation. The capable, informal/natural support may be paid for laundry, housekeeping, and meal prep under the following circumstances:

Meal Prep:
The waiver participant has a specialized diet that is prescribed by a physician and either requires specialized preparation or is designed specifically to meet the participant’s dietary needs as documented in the Service Plan. PCS shall only be authorized for the time spent preparing the waiver participant’s specialized diet. A specialized diet does not include simple differences in ingredients, preparing the same meal slightly different to meet the participant’s dietary restrictions.

Housekeeping
The waiver participant has documented incontinence issues or other specialized needs that create excessive housekeeping. Homemaker/chore services provided as part of PCS can only be incidental, and cannot comprise the entirely of the service. PCS performed should be specific to the needs of the waiver recipient as reflected in the personal care service plan.
Laundry:
The waiver participant has documented incontinence issues creating excessive laundry. PCS shall only be authorized for the time spent providing assistance with the participant’s excessive laundry. One unit of service equals 15 minutes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid overlap of services, PCS is limited to those services not covered through EPSDT, the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Personal Care Services provided in a home school setting must not be educational in purpose.

The scope, duration and amount of services authorized by the MCO shall be consistent with the participant's assessed need as documented in the Person-Centered Service Plan.

Personal Services is limited to up to 12 hours per 24-hour day (a unit of service is 15 minutes). The MCO may authorize services exceeding 12 hours per 24-hours if the participant meets one or more of the following criteria:
1. The additional request for PCS is critical to the remediation of the participant's abuse neglect, exploitation, or domestic violence issue.
2. The additional request for PCS is critical to the participant's ability to remain in the community in lieu of an institution.
3. The time additional request for PCS is a necessary support in order for the participant to remain in the community within the first three months of his/her return to the community from a prolonged stay (greater than 90 days) in an institution.

A person may have several PCS workers providing care on a variety of days at a variety of times, but a person may not have more than one PCS worker providing care at any given time. Person-Centered Service Plans for which it is determined that the provision of Personal Care Services would be a duplication of services will not be approved. The MCO will not make payments for multiple claims filed for the same time on the same date of service.

Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with Intellectual Developmental Disability (IDD), or institution for mental disease are not covered.

Self-Directed PCS will be paid through an enrolled fiscal management service agency.

Children receiving care in licensed foster care settings do not have the option to self-direct services. All services must be provided through the agency directed service model.

While Federal rules generally prohibit payments to legally responsible relatives for Personal Care Services, Kansas does allow such payments under the circumstances described in Appendix C-2-d. Legally responsible individuals who have a duty under State law to care for another person include:
(a) the parent (biological or adoptive) of a minor child; or the guardian of a minor child who must provide care to the child; or
(b) a spouse of a waiver participant

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Care Attendant/Personal Care Services provider
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:
Individual
Provider Type:

Personal Care Attendant/Personal Care Services provider

Provider Qualifications
License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

A. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider
B. Must have a High School Diploma or equivalent OR be at least eighteen years of age or older;
C. Complete KDADS Approved Skill Training requirements.
D. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications
Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:
Agency
Provider Type:

Home Health Agency

Provider Qualifications
License *(specify):*

K.S.A. 65-5001 et seq.

Certificate *(specify):*

K.S.A. 65-5115
K.A.R. 28-51-113

Other Standard *(specify):*

Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO).

a. Must have a High School Diploma or equivalent or be at least eighteen years of age or older;
b. Complete KDADS Approved Skill Training requirements.
c. Must reside outside of waiver recipient's home;
d. Complete any additional skill training needed in order care for the waiver participant as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-directio

Category 2:

12 Services Supporting Self-Direction

Sub-Category 2:

12020 information and assistance in support of self-direction

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Financial Management Services (FMS) is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model.

Services in support of participant direction are offered whenever a waiver affords participants the opportunity to direct some or all their waiver services. The participant is the sole employer of the direct service worker. The FMS provider is responsible for the provision of Information and Assistance tasks to assist the participant with understanding his or her role and responsibilities as the employer and his or her responsibilities under self-direction. The FMS Kansas Medical Assistance Program (KMAP) manual details the responsibilities of the FMS provider, waiver participant and the MCO.

FMS assists the participant or participant's representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant or legal guardian that the participant must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions including:
1. Verification and processing of time worked and the provision of quality assurance;
2. Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
3. Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
4. Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct support workers (DSW), managing workers, and providing effective communication and problem- solving.

Payment for FMS
FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for DSWs. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service does not duplicate other waiver services. Where the possibility of duplicate provision of services exists, the participant's Person-Centered Service Plan shall clearly delineate responsibilities for the performance of activities.
Access to this service is limited to participants who choose to self-direct some or all the service(s) when self-direction is offered.

FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid Provider of Financial Management Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider of Financial Management Services

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Enrolled FMS providers will furnish Financial Management Services according to the Kansas model. Organizations interested in providing Financial Management Services (FMS) are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment in KMAP to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually, and approval is subject to satisfactory completion of the required Generally Accepted Accounting Principles (GAAP) audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

For new organizations seeking to be a FMS provider, the FMS provider agreement and accompanying documentation are reviewed by KDADS and/or their designee to ensure that all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS, or designee.

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:

- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
- Including process for conducting background checks
- Process for establishing and tracking workers wage with the participant

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

In order to align this wavier service with federal requirements, the state will complete system changes to unbundle Assistive Services and submit a wavier amendment no later than 05/01/2021, in accordance with the timing agreed upon with CMS.

Assistive Services are those services which meet a participant's assessed need by modifying or improving a participant's home or otherwise enhancing the participant's ability to live independently in his/her home and community through the use of adaptive equipment. For the purposes of this waiver, adaptive equipment includes durable medical equipment, van lifts and communication devices.

Adaptations or an improvement to the home that is of general utility and is not of direct medical or remedial benefit to the participant is excluded.

Reimbursement for this service is limited to the participant's assessed level of service and based on the participant's Person-Centered Service Plan. All Assistive Services will be arranged by the MCO chosen by the participant, with the participant's written authorization of the purchase. Participants will have complete access to choose from all qualified providers with consideration given to the most economical option available to meet the participant's assessed needs. If a related vendor, such as a Durable Medical Equipment provider, does not wish to contract with the MCO or FMS provider, the State shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

Assistive Services are subject to critical situation criteria. One of the three criteria listed below must be present for the MCO to authorize Assistive Services.

1. The Assistive Services purchase is critical to the participant's ability to return to the community from the nursing facility and is a necessary expenditure within the first three months of the participant's return to the community. Planning for the use of any Assistive Service shall occur prior to a person's return to the community, when applicable. In all cases, the participant's chosen KanCare managed care organization must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described situations.

2. Participant previously left waiver services for a Planned Brief Stay, and the Assistive Services request is critical to the participant's ability to return to the community from the nursing facility or medical facility and is a necessary expenditure within the first three months of the participant's return to the community. Planning for the use of any Assistive Service shall occur prior to a person's return to the community, when applicable. In all cases, the participant's chosen KanCare
managed care organization must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described situations.

3. There has been a DCF substantiation of one of the following situations:
a. An Adult Protective Services investigation outcome of abuse, neglect or exploitation; or
b. A Child Protective Services investigation outcome of abuse or neglect; or
c. The participant is a recent victim of documented domestic violence.

All participants are held to the same criteria when qualifying for critical situation approval as in accordance with statewide policies and guidelines. Children under 21 years of must receive all medically necessary state plan services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under the Physically Disabled Waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives.

Assistive Services are limited to the participant's assessed level of service need, as specified in the participant's Person-Centered Service Plan. There is a $7,500 maximum lifetime expenditure, across waivers with the exception of the I/DD Waiver. This limit was set based on the available waiver funds appropriated by the Kansas Legislature. The MCOs are required to provide services to meet participants health and safety needs. They have the option to authorize any services necessary for health and safety.

To avoid overlap of services, Assistive Service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort via the participant's Person-Centered Service Plan.

- Purchase or rent of new or used assistive technology is limited to those items not covered under the State Plan.
- DME can only be accessed after a participant is no longer eligible for EPSDT services through the State Plan.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant.

The services under the Physically Disabled Waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Durable Medical Equipment
Agency	Durable Medical Equipment provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:
Individual
Provider Type:

Durable Medical Equipment

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Must affiliate or subcontract with a recognized Center for Independent Living or licensed home health agency (as defined in
K.S.A. 65-5001 et seq.).
Applicable work must be performed according to local and county codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:

Agency

Provider Type:

Durable Medical Equipment provider

Provider Qualifications

License *(specify):*

HHA: K.S.A. 65-5001 et seq.
Pharmacy:
Rural Health Clinic:

Certificate *(specify):*

HHA: K.S.A. 65-5115; K.A.R. 28-51-113

Other Standard *(specify):*

- As described in K.A.R 30-5-59
- As described in K.S.A. 65-1626
- Medicaid-enrolled provider

DME as a part of Assistive Services may be provided by all of the following:

- Licensed Home Health Agency
- Durable Medical Equipment provider
- Pharmacy
- Rural Health Clinic (medical supplies only)
- Welding Shop (oxygen only)

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

A provider of services for a participant in foster care, adopted or part of KanBeHealthy may be excluded from the above requirements if a determination is made that a medically necessary piece of durable medical equipment can be cost-efficiently obtained only from a provider not otherwise eligible to be enrolled according to the current program guidelines.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Enhanced Care Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Enhanced Care Services provides non-nursing physical assistance and/or supervision during the participant's normal sleeping hours in the participant's place of residence. This assistance includes the following: physical assistance or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and prompting to take medication.

Providers will sleep and awaken as identified on the participant's Person-Centered Service Plan and must provide the consumer with a mechanism to gain their attention or awaken them at any time (e.g., a bell or buzzer). Providers must be ready to call a physician, hospital, any identified contact individuals, or other medical personnel should an emergency arise. The scope of and intent behind Enhanced Care Services is entirely different from and therefore not duplicative of services defined as and provided under Personal Services.

Providers cannot live in the participant's home unless the provider qualifies for an exception, granted by the MCO, under the legally responsible exception.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Only one unit (a minimum of 6 hours) is allowed within a 24-hour period.
- ECS in combination with other HCBS services cannot exceed 24 hours within a 24-hour period.
- To avoid overlap of services, ECS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

- The participant's Service Plan must document an assessed need for this service beyond what can be provided through Personal Emergency Response System (PERS) services.

- ECS must be provided in the participant's home. Services providers must remain in the Participant's home for the duration of this service provision in accordance with the Participant's Service Plan.
- Participants residing in an institution, assisted living facility or residential setting or other type of group home are not eligible for ECS.

- ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest mitigated as ordered by the probate court or a designated representative is appointed to direct the care of the participant. Please see C-2-d, explaining that the guidelines for when legally responsible relatives can provide this service are described there.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	ECS provider
Individual	ECS provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:
Agency
Provider Type:

ECS provider
Provider Qualifications
License *(specify):*

Not applicable
Certificate *(specify):*

Not applicable
Other Standard *(specify):*

The agency must be a Medicaid enrolled provider, contracted and credentialed with Kancare MCO. The requirements pertaining to age and the ability to call the appropriate individual are for individual employees of the agency providing ECS, and the requirement to be an enrolled Medicaid provider pertains to the agency itself.
Verification of Provider Qualifications
Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.
Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:
Individual
Provider Type:

ECS provider
Provider Qualifications
License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

1. Be at least eighteen years of age; or
2. Must have a High School Diploma or equivalent;
3. Must have the ability to call appropriate individual/organization in case of an emergency and provide the intermittent care the individual may need
4. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider, acting as an administrative agent on behalf of the participant.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home-Delivered Meals Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Home-Delivered Meals service provides a participant with one (1) or two (2) meals per calendar date. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements which may not compromise a full nutritional regimen. The meals are prepared elsewhere and delivered to a participant's residence. Participants eligible for this service have been determined functionally in need of the Home-Delivered Meals service as indicated by the functional eligibility assessment and authorized in the Person-Centered Service Plan. Meal preparation by Physical Disability (PD) waiver Personal Care Services providers may be authorized in the Service Plan for those meals not provided under the Home-Delivered Meal service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to participants who require extensive routine physical support for meal preparation as supported by the participant's functional eligibility assessment.

This service may NOT be maintained when a participant is admitted to a nursing facility or acute care facility for a planned brief stay not to exceed two months following the admission month in accordance with Medicaid policy. This service is available in the participant's place of residence, excluding assisted living and Home Plus facilities.

To avoid overlap of services, Home Delivered Meals are limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

- This service may not duplicate home-delivered meals provided through the Older Americans Act
- This service is not duplicative of meal preparation provided by attendants through Personal Care Services.

No more than two (2) home-delivered meals will be authorized per participant for any given calendar date.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved and Medicaid-enrolled nutrition provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Delivered Meals Service

Provider Category:

Agency

Provider Type:

Approved and Medicaid-enrolled nutrition provider agency

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Provider must have on staff, or be contracted with, a certified dietician to assure compliance with KDADS nutrition requirements for programs under the Older Americans Act.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in KSA 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medication Reminder Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care

Category 2: 14 Equipment, Technology, and Modifications

Sub-Category 2: 14031 equipment and technology

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Medication Reminder Services provides a scheduled reminder to a participant when it is time for the participant to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the providers system.

Medication Reminder/Dispenser is a device that houses a participant's medication and dispenses the medication with an alarm at programmed times.

Medication Reminder/Dispenser Installation is the placement of the Medication Dispenser in a participant's home.

Education and assistance with all Medication Reminder Services is made available to participants during implementation and on an ongoing basis by the provider of this service.

Medication Reminder Service is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

-Routine maintenance of rental equipment is the provider's responsibility.
-Repair/replacement of rental equipment is not covered.
-Rental of equipment is covered.
-Purchase of equipment is not covered.
To avoid overlap of services, Medication Reminder is limited to those services not covered through EPSDT, the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan. This service is not duplicative of services offered free of charge through any other agency or service.
These systems may be maintained on a monthly rental basis even if a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is available in the participant's home. Medication Reminder service is not provided face-to-face with the exception of the Installation of Medication Reminder/Dispenser.

Installation of Medication Reminder/Dispenser is limited to one installation per participant per calendar year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medication Reminder Services Provider/Dispenser Provider/ and Installation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Services

Provider Category:

Agency

Provider Type:

Medication Reminder Services Provider/Dispenser Provider/ and Installation Provider

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Any company providing medication reminder services per industry standards is eligible to contract with KanCare as a Medication Reminder Services.

Medication Reminder Service providers must provide appropriate training to their staff on medication administration and dispensing of medication.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System and Installation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable participants at high risk of institutionalization to secure help in an emergency. The system is connected to the participant's telephone and programmed to signal a response center once the "help" button is activated. The participant may wear a portable "help" button to allow for mobility. PERS is limited to those individuals who:

1. Are alone for significant parts of the day, AND
2. Have no regular attendant (formal or informal) for extended periods of time, AND
3. Who would otherwise require extensive routine supervision.

The PERS system has a back-up battery that is activated if an emergency situation develops. The back-up battery will activate if there is interference with the landline and connection through the cell phone will remain as long as the cell phone towers are intact. If the system is not functioning properly, the provider will attempt to contact the participant through the PERS system. If unable to communicate with the participant, the provider contacts the participant-selected responders to contact with the participant in a 15-20-minute window. If the PERS provider is unable to reach the responders, then the provider will contact 911/EMS to check on the unresponsive participant. In addition, the PERS system should be checked once a month to ensure that it is functioning properly, and the back-up battery is functional. Participants have the ability to turn off/unplug the PERS system; however, turning off the system will trigger an alert to the PERS provider. The provider will follow up with the participant to ensure his/her health and welfare. The PERS provider must receive permission from the participant for the use of the device in the home.

PERS Installation is the placement of electronic PERS devices in a participant's residence. These participants have met the assessed need of a Personal Emergency Response System.

Personal Emergency Response System and Installation is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid any overlap of services, PERS is limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources. PD waiver funding is used as the funding source of last resort and requires prior authorization from the participant's chosen KanCare MCO.

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of equipment is not covered.
- Rental of the PERS System is covered; purchase is not.
- Call lights do not meet this definition.
- Maximum of two PERS Installations per calendar year.

- PERS is based on the assessed need of the individual and authorized in the Person-Centered Service Plan.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS and PERS Installation provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System and Installation

Provider Category:
Agency
Provider Type:

PERS and PERS Installation provider

Provider Qualifications

License *(specify):*

Not applicable

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Must be an enrolled Medicaid provider.
Must conform to industry standards and any federal, state, and local laws and regulations that govern this service.
The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- (●) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ( ) **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - [ ] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - [ ] **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - [ ] **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - [ ] **As an administrative activity.** *Complete item C-1-c.*
  - [ ] **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ( ) **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All HCBS providers shall perform background checks in accordance with the KDADS' Background Check policy, and shall comply with all regulations related to Abuse, Neglect and Exploitation.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.
Community Service Providers (CSPs)are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CSPs may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS,,KDHE and KanCare MCO staff.
Background checks are required of employees regardless of whether they are providing a licensed or non-licensed service. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process.
The employer shall submit a request for the following checks:
1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver's license record check through the Kansas Department of Revenue (KDOR)
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All HCBS providers shall perform background checks in accordance with the KDADS' Background Check policy.
All HCBS providers are required to pass DCF abuse registry checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.
All HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, KDHE and KanCare MCO staff.
KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings.
All HCBS providers are required to pass ANE checks conducted by the following entities.
1. a check for ANE through the Nurse Aid Registry
2. an adult and child ANE check through Department of Children and Families (DCF)

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	
Home Plus	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in the State's HCBS Settings Transition Plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Medication Reminder Services	☐
Personal Emergency Response System and Installation	☐
Home-Delivered Meals Service	☐
Enhanced Care Service	☐
Assistive Services	☒
Financial Management Services	☐
Personal Care Services	☒

Facility Capacity Limit:

Six (6) or more

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the

following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Home Plus

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Medication Reminder Services	☐
Personal Emergency Response System and Installation	☐
Home-Delivered Meals Service	☐
Enhanced Care Service	☐
Assistive Services	☒
Financial Management Services	☐
Personal Care Services	☒

Facility Capacity Limit:

Not more than eight (8)

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

KDADS recognizes that families as Personal Care Services providers are an important part of our service delivery system.
A guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest is mitigated.

1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068.
a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
b. A copy of the special or annual report in which the conflict of interest is disclosed will be provided to the MCO and FMS provider if along with the judge's order approving the annual or special report and determining that there is no conflict of interest for the guardian to be paid to provide supports for the participant under the HCBS program.
2. If the court determines that all potential conflict of interest concerns have not been mitigated, the legal guardian can:
a. Select someone (family member or friend) to provide the HCBS services to the participant. If a family member or friend is not available, the participant's selected MCO or FMS provider can assist the legal guardian in finding a direct support worker or seeking alternative HCBS service providers in the community, OR
b. Select someone (family member, friend, non-paid guardian) to appoint as a Designated Representative to develop the integrated service plan and direct the participant's services under HCBS.
3. An activated durable power of attorney (A DPOA who is currently authorized to make financial, medical or other decisions on behalf of the participant) is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual's care (hire, fire, manage, training, and monitor direct support workers).
4. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available to the participant if the exception was not granted.
Legal guardians may be paid for providing PCS services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.
The legal guardian or DPOA of an adult participant may provide, whenever the relative/legal guardian is qualified to provide Personal Care Service (PCS), self-directed (PCS) as specified in Appendix C-3.

☒ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The State of Kansas does not prevent non-legally responsible relatives from providing PCS and ECS services. The non-legally responsible relative is subject to the same requirements as detailed in the service definition and provider qualification in Appendix C.
The State of Kansas defines legally responsible individuals as:
1) the parent (biological or adoptive) of a minor child;
2) a spouse of a waiver participant;
3) the legal guardian or activated DPOA of a waiver participant;
4) a foster parent.

KDADS allows legally responsible individuals to provide PCS or ECS under the following circumstances:
1.A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflicts of interest have been mitigated in accordance with K.S.A. 59-3068.
a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as
required by guardianship law and to maintain documentation regarding the determination of the court.
b. It shall be the responsibility for the legal guardian to provide to the MCO and FMS provider a copy of the special or annual report in which the conflict of interest is disclosed and a copy of the judge's order or approval determining that there is no conflict of interest for the guardian to be paid to provide HCBS supports for the participant. 2. If the court determines that all potential conflicts of interest have not been mitigated; or the legal guardian otherwise chooses to provide personal care services, the legal guardian shall select a designated representative, who is not a legally responsible individual for the participant, to develop the Person-Centered Service Plan and direct the participant's HCBS services.
3. An A-DPOA, who is currently authorized to make financial, medical or other decisions on behalf of the participant, is not permitted to be a paid provider unless a designated representative is appointed to direct the individual's care.
4. The MCO may grant an exception to the above listed criteria when one of the three circumstances is present:

1) The participant lives in a rural area, in which access to a provider is beyond a 50 mile radius from the participant's residence and the relative or family member is the only provider available to meet the needs of the participant.

2) The participant lives alone and has a severe cognitive impairment, physical disability or intellectual disability

3) The participant has exhausted other support options offered by the MCO and absent ECS would be at significant risk of institutionalization.
The controls that are employed to ensure that payments are made only for services rendered include: MCO quarterly Quality Reviews to monitor that services that are provided are approved in the Person-Centered Service plan, monitoring of PCS or ECS services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Kansas provides for continuous, open enrollment of waiver service provider by way of an online provider enrollment portal (see https://www.kmap-state- ks.us/Public/provider.asp). The online portal also contains training materials and other useful information that prospective providers may access at their convenience, including a tip sheet and provider enrollment training video. The adequacy of MCO provider networks is monitored quarterly via standardized reports submitted through the KanCare Reporting System. HCBS waiver program management staff are maintained on a report distribution list and notified when a new report submission is received. Whenever the number of providers falls below the established network adequacy threshold, the HCBS program manager works with the MCO and KDHE to develop an action plan for achieving the required threshold.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of new licensed/certified waiver provider applicants that initially met licensure requirements,certification requirements,and other waiver standards prior to furnishing waiver services N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc. prior to furnishing waiver services D=Number of all new licensed/certified providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
D=Number of enrolled licensed/certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCOs
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agenccy	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers

Data Source (Select one):

Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of non-licensed/non-certified waiver providers that continue to meet waiver requirements N=Number of non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of non-licensed/non-certified waiver provider

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCOs

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of active providers that meet training requirements N=Number of providers that meet training requirements D=Number of active providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff request, approve, and assure implementation of corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through the quality review process. These processes are monitored by both program managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the HCBS quality strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
KanCare Managed Care Organizations (MCOs)	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State has proposed a Statewide Transition Plan for residential and non-residential settings to comply with federal HCBS setting requirements, pending approval from CMS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community Based Services (HCBS) services as one part of the comprehensive KanCare program. The MCOs are responsible for development of the Person-Centered Service Plan (Service Plan) in accordance with KDADS' Person-centered Service Plan policy. The MCO or their designee will use their staff to provide this service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

MCOs and providers follow the processes outlined in the KDADS' Person-Centered Service Plan policy to provide the individual with the maximum amount of opportunity to direct and be actively engaged in the person-centered planning process.

Each participant found eligible for PD waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that are available to the participant. The participant, MCO, or the MCO's designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant's chosen provider.

The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Person-Centered Service Plan process and expectations are outlined in the KDADS' Person-Centered Service Plan policy.

a) MCOs may use contracted entities to assist in the development and monitoring of the Person-Centered Service Plan (Service Plan) but has primary responsibility for Service Plan development and accountability to deliver all Medicaid covered services included in a participant's Service Plan. The initial and annual Service Plans are developed during a face-to-face meeting with the participant, legal representative (if applicable), the MCO and selected representatives that the participant chooses to be involved. The date and time of the Service Plan meeting is coordinated based on the convenience of the participant and the participant's representative, if applicable. The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The KDADS' Person-Centered Service Plan policy outlines who the required participants are in the development of the Service Plan. MCOs, or their designee, are required to invite known HCBS providers for the individual to the Service Plan meeting unless otherwise specified by the individual. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting. If the participant has a court-appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on the Service Plan.

The Service Plan is valid for 365 days from the date of the participant's and/or legal representative's signature unless there is a change in condition that requires an update to the Service Plan as detailed in the Person-Centered Service Plan policy.

b) All applicants for program services must undergo a functional eligibility assessment to determine functional eligibility for the PD waiver. The FEI is utilized to determine the level of care (LOC) eligibility for the PD waiver. The state's functional eligibility contractor conducts an assessment of the individual within the timeframe specified in the contract, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant within six months and must address physical, behavioral and functional needs in the Person-Centered Service Plan that identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle.

The participant will complete a Participant Interest Inventory (PII). The PII is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Service Plan meeting and will use the PII to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

c) Each participant found eligible for PD waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that is available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant's chosen provider.

d) Through the various assessments and Service Plan related documents described in b) above, the participant's goals, needs, and preferences are at the forefront of developing their Service Plan. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.

e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS' Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, upon MCO notification or awareness of necessitating circumstances. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature

and severity of the participant's disability. Additional meetings may be necessary due to changes in conditions or circumstances.

f) The responsibilities for implementing and monitoring the delivery of services as authorized in the Service Plan are detailed in the Person-Centered Service Plan policy and the HCBS Quality Review Policy. MCOs shall conduct one face-to-face or telephonic visit with the participant within 30 days of transitions from any alternate setting of care, after which the MCO must follow up with quarterly telephone calls and face-to-face visits every six months.

g) The requirements for how and when the Service Plan are updated are specified in the KDADS' Person-Centered Service Plan policy. The MCOs conduct periodic reviews, as specified by the KanCare MCO contracts, to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in conditions or circumstances. Additional Person-Centered Service Plan meetings may be necessary due to changes in conditions or circumstances that require updates to the participant's plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant's wishes and needs:
1) Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability;
2) Change in behaviors that may lead to loss of foster placement or removal from the home;
3) Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan;
4) Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater;
5) Upon the request of any waiver participant, guardian or legal representative;
6) Any health and/or safety concern;
7) Any change in needs for an HCBS recipient not listed above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument and the MCO needs assessment which identifies potential risk factors. The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers. The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met. The Participant Interest Inventory (PII), a document that is a part of the Service Plan, describes, in the participant's own words, how the participant would like their supports to be provided. This includes any interventions that are identified as necessary to mitigate risk to the participant's health safety and welfare (PII Risk Assessment & Intervention Plans).

Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the Person-Centered Service Plan policy.

A back-up plan for each individual is established during the needs assessment and Person-Centered Service Plan development. This and other information from the assessment and annual re-assessment are incorporated into a backup plan which is utilized to mitigate risk related to extraordinary circumstances. Backup plans are developed according to the unique needs such as physical limitations and circumstances, such as the availability of informal supports of each participant. Backup arrangements are added to Service Plans and identify key elements, including specific strategies and contact individuals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The State assures that each participant will be given free choice of all qualified providers of each service included in his/her written Person-Centered Service Plan. The MCO provides each eligible participant with a list of providers from which the participant can choose a service provider. The MCO assists the participant with accessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers for waiver services identified in their Person-Centered Service Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

KDADS conducts quarterly reviews of the MCOs to ensure that the performance measures outlined in the waiver application are met. As part of the review, the initial, annual and current Person-Centered Service Plan are reviewed to insure compliance with performance standards. KDADS reports to KDHE on the findings of the audits during the quarterly audit meetings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

Service plans and related documentation will be maintained by the consumer's chosen KanCare MCO, and will be retained at least as long as this requirement specifies.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The MCOs are responsible for monitoring the implementation of the Person-Centered Service Plan and for ensuring the health and welfare of the participant with input from the PD Program Manager and KDADS Regional Field Staff. Service Plan implementation is assessed through the comprehensive statewide KanCare Quality Improvement Strategy (which includes all of the HCBS waiver performance measures). Kansas also monitors the Adverse Incident Reporting system and implements corrective action plans for remediation with the MCOs.

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether to self-direct their services;
- Services meet participant's needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant's health and safety are assured, to the extent possible; and
- Participants have access to Medicaid State Plan services when the participant's need for services has been assessed and determined medically necessary.

Individual monitoring by the MCOs is defined as:
•Face-to-face meetings will occur in accordance with the Person-Centered Service Plan policy.
•Face-to-face meetings between MCO and participant are required every six months to evaluate the participant's ongoing needs
•Face-to-face meetings are expected if the participant has a significant change in needs, eligibility, or preferences that will modify the participant's current Person-Centered Service Plan.
•Contact with the participant on a monthly basis is required if the participant's health and welfare needs are at risk of significant decline or the participant is in imminent risk of death or institutionalization.

Face-to-face meetings are expected if the participant has a significant change in needs, eligibility, or preferences that will modify the participant's current Person-Centered Service Plan.

In addition, the Person-Centered Service Plan and choice are monitored by state quality review staff as a component of waiver assurance and minimum standards. Any issues in need of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation and reported to the PD Program Manager.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. The HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency are part of this strategy.

State staff request, approve, and ensure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address participants' goals N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address health and safety risk factors N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%

☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver N = Number of waiver participants whose service plans were developed according to the processes in the approved waiver D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organization	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants with a documented change in needs whose service plan was revised, as needed, to address the change N=Number of waiver participants with a documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of survey respondents who reported receiving all services as specified in their service plan N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by the QMS (Quality Management staff)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Customer interviews, on-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group:

		Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other

If 'Other' is selected, specify:
Record Reviews and Electronic Visit Verification (EVV) reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's resulst as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care N = Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D = Number of waiver participants whose files are reviewed for the documentation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D= Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative N = Number of waiver participants whose record contains documentation indicating a choice of community-based services D = Number fo waiver participants whose files are reviewed for the documentation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%

☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers

D=Number of waiver participants whose files are reviewed for the documentation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring.
Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) All participants of PD waiver services have the opportunity to choose the KanCare managed care organization that will support them in overall service access and care management. The opportunity for participant direction (self-direction) of Personal Services and Enhanced Care Services is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100).
This opportunity includes specific responsibilities required of the participant, including:
1.Recruitment and selection of Personal Care Service(PCS) worker, back-up PCS and Enhanced Care Services Financial Management Service (FMS) providers;
2. Assignment of service provider hours within the limits of the authorized services;
3. Complete an agreement with an enrolled Financial Management Services (FMS)provider;
4. Referral of providers to the participant's chosen FMS provider;
5. Provider orientation and training;
6. Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
7. Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
8. Other monitoring of services; and
9. Dismissal of the worker, if necessary.

b) Participants are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant's Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant's Person-Centered Service Plan. The MCO supports the participant who selects self-direction of services by monitoring services to ensure that they are provided by Personal Care Attendants and Enhanced Care Services attendants in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow- up activities.

c) The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider. FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks:(1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:
- Verification and processing of time worked and the provision of quality assurance;
- Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
- Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
- Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing

identified supports and services;

4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction option is available for Personal Care Services and Enhanced Care Services.
Participant-direction is offered for the following services:

Enhanced Care Services
Financial Management Services
Assistive Services- Home Modifications
Personal Care Services

Self-direction is not an option when the participant/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be documented by the MCO and is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self-direct services:

- the limitation to Personal Services and Enhanced Care Services;
- the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
- related responsibilities (outlined in E-1-a);
- potential liabilities related to the non-fulfillment of responsibilities in self-direction;
- supports provided by the managed care organization (MCO) they have selected;
- the requirements of personal care attendants;
- the ability of the participant to choose not to self-direct services at any time; and
- other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency- directed services.

b) The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chosen this option and identified an enrolled provider. This information is available from the PD Program Manager, KDADS Regional Field Staff, and the PD KMAP Manual.

a) Information regarding self-directed services is initially provided by the MCO during the Person-Centered Service Plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's Person-Centered Service Plan. This information is reviewed at least annually with the member. The option to end self-direction can be discussed, and the decision to choose agency-directed services can be made at any time.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

To ensure that non-legal representatives' function in the best interests of the participant, additional safeguards are in place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self-direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the participant's case file, certain situations arise, particularly when the participant's health and welfare needs are not being met. In addition, post- pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS Quality Management Specialist and/or MCO staff serve to monitor participant services and serve as safeguards to ensure the participant's best interests are followed. Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Participant-direction by a representative is subject to 42 CFR 441.301(1)(vi) and in accordance with D-1-b.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the individualized plan of care. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest available on the KDADS website: www.kdads.ks.gov/docs/default-source/CSP/HCBS/HCBS-Policies/kansas-hcbs-conflict-of-interest-policy---6-15-15.pdf?sfvrsn=2

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Enhanced Care Service	☒	☐
Assistive Services	☒	☐
Financial Management Services	☒	☐
Personal Care Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled FMS providers furnish Financial Management Services using the Employer Authority provider model. Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are reimbursed a monthly fee per participant through MMIS. The per member per month payment is based on a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FFS rate.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) The State assess the performance of the FMS providers through the annual GAAP audit reports, performed by an independent CPA, submitted to KDADS. In addition, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit KDHE or KDADS, their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59). KDADS monitors and verifies accurate tracking of service provided by self-directed providers and paid out through the FMS providers via the Electronic Visit Verification system and accompanying suite of reports. State and MCO staff work together to address/remediate any issue identified in accordance with the KDADS Financial Management Service policy. FMS providers contract with the MCOs to support KanCare members and are included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

(b) KDADS is responsible for the monitoring that occurs through the EVV system. The MCOs are accountable to ensure the FMS providers comply with their contract and State policy which outlines the requirements for annual GAAP audits. KDADS accepts the remittance for unused funds from the FMS providers and remits the federal portion to KDHE for disbursement back to Medicaid.

(c) The MCOs verify that FMS providers meet provider qualification requirements in the HCBS waivers in accordance with the KDADS Provider Qualifications policy. The FMS providers are responsible for obtaining a GAAP audit each year. The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their

services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**
Information and assistance in support of
participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Medication Reminder Services	☐
Personal Emergency Response System and Installation	☐
Home-Delivered Meals Service	☐
Enhanced Care Service	☐
Assistive Services	☐
Financial Management Services	☒
Personal Care Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Participants may access independent advocacy through the local Department for Children and Families, Aging & Disability Resource Center, MCO Care Coordinator or by directly contacting the Disability Rights Resource Center (DRC).

The Disability Rights Center of Kansas is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC operates eight federally authorized and funded protection and advocacy programs in Kansas. Participants are referred directly to DRC from various sources including KDADS.

Various community and disability organizations such as the Cerebral Palsy Research Foundation offer independent advocacy for Kansas participants.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

One of the participant's opportunities, as well as responsibilities, is the ability to discontinue self-direction. At any time, if the participant chooses to discontinue self-direction, he/she is to:

- Notify all providers as well as the Financial Management Services (FMS) provider.
- Maintain continuous attendant coverage for authorized Personal Care Services and/or Enhanced Care Services.

- Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the participant, to allow for the coordination of service provision.

The duties of the participant's KanCare MCO include:

- Explore other service options and complete a new Participant Choice form with the participant; and
- Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources
- Work with the participant to maintain continuous coverage as outlined and authorized in the participant's Service Plan.
- The MCO, though their care management and monitoring activities, works with the participant's self-directed provider to assure participant health and welfare during the transition period.
- Ensure open communication with both the participant and the self-directed provider, monitor the services provided, and gather continual input from the participant as to satisfaction with their services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The participant's chosen KanCare MCO or the KDADS may discontinue self-direction and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:
1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if the health and welfare needs of the participant are not met as observed by the MCO or confirmed by the Kansas Department of Children and Families (DCF) Adult Protective Services (APS);
3. if the direct support worker has not adequately performed the services as outlined in the Peron-Centered Service Plan (Service Plan);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or service provider has abused or misused self-direction including:
a. the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the needs assessment and/or POC;
b. the participant/representative has directed the service providers to provide, and the service providers has in fact provided paid comprehensive support or Enhanced Care Services beyond the scope of the service definition;
c. the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the Service Plan;
d. the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the service providers for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:
1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participants attending physician or RN no longer authorizes the participant to self-direct his/her care; or
3. the participant/representative has committed a fraudulent act.

A timely Notice of Action (NOA) shall be sent to the participant prior to the effective date for termination of the participant's participation in the Self-Directed Care Option. The MCO coordinates to ensure there is not a lapse in service delivery.

The MCO works with the participant to maintain continuous attendant coverage as outlined and authorized on the participant's Service Plan. The MCO, though their care management and monitoring activities, works with the participant's choice of a non-self-directed agency to assure participant health and welfare during the transition period and beyond by communicating with both the participant and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the participant as to satisfaction with services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	6472	
Year 2	6472	
Year 3	6472	
Year 4	6472	
Year 5	6472	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The direct service worker (provider) covers the cost of the criminal history and/or background investigation of staff should the participant request one.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the state's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Request for Fair Hearing Regarding a Functional Eligibility Determination:

Kansas has contracted with independent assessors to conduct level of care determinations (functional eligibility).
Decisions made by the independent assessors are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors with their decision on the LOC determination/redetermination.

Applicants/beneficiaries may file only a fair hearing for an adverse decision by MCO:

KanCare Managed Care Organizations (MCOs) are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member.

Each participant is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. Participant grievance processes and Fair Hearing processes can also be found at the KanCare website.

KanCare participants have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 calendar days of receipt, and written response to the grievance will be given to the participant within 30 calendar days (except in cases where it is in the best interest of the member that the resolution timeframe be extended). If the MCO fails to send a grievance notice within the required timeframe, the participant is deemed to have exhausted the MCO's appeal process, and the participant may initiate a State Fair Hearing.
An appeal can only occur under the following circumstances:

- If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction,
suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
- Members will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: Members or (a friend, an attorney, or anyone else on the member's behalf can file an appeal).
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 60 days calendar days plus 3 calendar days after the participant has received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant's appeal will be resolve in 45 calendar days.

Fair Hearings

A member may request a Fair Hearing upon receiving a Notice of Action.

A Fair Hearing is a formal meeting where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all the facts and then hears motions, conduct hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge.
If the participant is not satisfied with the decision made on the appeal, the participant or their representative may ask for a fair hearing. The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision.
The request be submitted in writing and mailed or faxed to:
Office of Administrative Hearings 1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

Participants have the right to benefits continuation of previously authorized services while a hearing is pending and can request such benefits as a part of their fair hearing request. All three MCOs will advise participants of their right to a State Fair Hearing. Participants have to finish their appeal with the MCO before requesting a State Fair hearing.

For all KanCare MCOs:
In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the
welcome packet provided to each member. It will also be posted online at the MCOs' member web site. In addition, every notice

of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

The State requires that all MCOs define an “action” pursuant to the KanCare contract and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event their Medicaid application is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR
§438.52(b)(2)(ii), to obtain services outside the network.

MCOs retain all Notices of Action in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. Participants have the right to submit grievances or appeals to their assigned managed care organization. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), requires the managed care organizations to operate a member grievance and appeal system consistent with federal regulations and Attachment D of the State's contract with CMS. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1. KanCare members are informed that filing an appeal with the MCO is a prerequisite for a Fair Hearing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are part of the State's fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State's fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. The fiscal agent team escalates any grievance prior to the 3-occurrence timeframe based on the severity of the grievance. Through the escalation processes the fiscal agent team contacts KDADS, KDHE or the appropriate local authority who have access to this information at any time to ensure the member's safety and wellbeing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time.

Participants who are not part of the Kancare program are part of the State's fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State's fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for- service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager, or by the Ombudsman's office.

Complaints are received in the DXC Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately.
Grievance Unit must make contact related to a grievance within 3 business days. If the situation is urgent, the grievance staff make contact immediately. The grievance is required to be resolved within 30 calendar days.

As part of its regulatory role to educate consumers regarding their rights and responsibilities, CDDOs educate consumers regarding their due process rights including the complaint/grievance process and the fair hearing process. DDRA and implementing regulations available to submit to CMS upon request.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or

Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Definitions of Kansas Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 39, Article 14 for adults:

K.S.A. 39-1430. Abuse, Neglect or Exploitation of certain adults:

K.S.A. 39-1430(b): Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a waiver participant, including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult; 4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5) a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6) Fiduciary Abuse; or 7) omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

K.S.A. 39-1430(c): Neglect: The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

K.S.A. 39-1430(d): Exploitation: Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

K.S.A. 39-1430(e): Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit.

Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 38, Article 22 for children:

Neglect - K.S.A. 38-2202(t): Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include, but shall not be limited to:

- (1) Failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation which requires judgment or actions beyond the child's level of maturity, physical condition or mental abilities and that results in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent; however, this exception shall not preclude a court from entering an order pursuant to K.S.A. 2018 Supp. 38-2217(a)(2), and amendments thereto.

Physical, Mental or Emotional Abuse - K.S.A. 38-2202(y): The infliction of physical, mental or emotional harm or the causing of a deterioration of a child and may include, but shall not be limited to, maltreatment or exploiting a child to the extent that the child's health or emotional well-being is endangered

- Sexual Abuse - K.S.A. 38-2202(ff): Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child or another person. Sexual abuse shall include, but is not limited to, allowing, permitting or encouraging a child to:
  - (1) Be photographed, filmed or depicted in pornographic material; or
  - (2) be subjected to aggravated human trafficking, as defined in K.S.A. 2018 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another, or be subjected to an act which would constitute conduct proscribed by article 55 of chapter 21 of the Kansas Statutes Annotated or K.S.A. 2018 Supp. 21-6419 or 21-6422, and amendments thereto.

Abandonment - K.S.A 38-2202 (a): To forsake, desert or, without making appropriate provision for the substitute care,

cease providing care for the child.

Fiduciary Abuse - K.S.A. 39-1430(e): A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit

All DCF reportable events including Abuse, Neglect, Exploitation, and Fiduciary Abuse are required to be reported to the Kansas Department for Children and Families and once a determination has been made by DCF, the event must be entered into the Adverse Incident Reporting (AIR) system by KDADS if the event has not yet been entered by DCF staff in accordance with KDADS HCBS Adverse Incident Monitoring Standard Operating Procedure (SOP).

Reporting KDADS defined adverse incident requirements:

Other adverse incidents to be reported by KDADS staff into AIRS include, Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusion, and Restrictive interventions. See KDADS HCBS Adverse Incident Reporting and Management policy 2017-110 for definitions of all adverse incidents that are required to be reported by KDADS staff.

Additionally, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110. These acts include all use of restraints, seclusion and restrictive intervention.

Identification of the individuals/entities that must report critical events and incidents:

The Kansas statutes K.S.A. 39-1431 and K.S.A. 38-2223 identify mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult or minor immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Specifically, mandated reporters include: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF) and Substance Abuse Treatment Facilities. All other individuals who may witness a reportable event may voluntarily report it.

The timeframes within which critical incidents must be reported:

The timeframes within which critical incidents must be reported: KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days, of receiving the information. Outside of working hours, the reports shall be submitted to DCF on the first working day that the Kansas Department for Children and

Families is in operation after the receipt of such information.

All reports of suspected Abuse, Neglect, Exploitation, and Fiduciary Abuse must be reported to the Kansas Department for Children and Families promptly and in accordance with K.S.A. 39-1431 for adults and K.S.A. 38-2223 for children. All other adverse incidents as defined by KDADS in this section and as defined in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 must be reported directly into the AIR system no later than 24 hours of becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110.

The method of reporting:

Reports shall be made to the Kansas Department for Children and Families during the normal working week days and hours of operation. Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330 or online at http://www.dcf.ks.gov/Pages/Report-Abuse-or-Neglect.aspx. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911. All reports directed to DCF will be uploaded into the web-based Adverse Incident Reporting system (AIR).

Kansas Department for Children and Families reportable incidents and all KDADS defined adverse incidents must be reported directly into AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP. These include, in addition to suspected incidents of Abuse, Neglect, Exploitation or Fiduciary Abuse: Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Restraint, Seclusion, E/R visit, Hospitalization, Misuse of Medications, Natural Disaster, Serious Injury, Suicide, Suicide Attempt. See KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110 for definitions of KDADS reportable adverse incidents. Also, the reporter can select as many adverse incidents as may apply per that particular situation. Anyone who suspects a child or adult is experiencing any of the above types of DCF reportable events or KDADS adverse incidents may also report it through the DCF hotline.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development. Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant’s Person-Centered Service Plan. The information provided by the MCOs is consistent with the state’s Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

- The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.

The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of the reporter becoming aware of the adverse incident by direct entry into the KDADS web-based AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP.

- The entity that is responsible for evaluating reports and how reports are evaluated:

All reports of Abuse, Neglect, Exploitation and Fiduciary Abuse are reported to and investigated by DCF. Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with, K.S.A. 38-2223 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS, which is entered into AIRS and reviewed by KDADS staff.

KDADS is the entity responsible for evaluating all adverse incident reports in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS HCBS Adverse Incident Monitoring SOP. All events reported to AIRS are reviewed by KDADS staff to determine whether or not they meet the SOP definition of an adverse incident. Those that do not are screened out from further investigation by KDADS. Those that meet the definition are investigated by KDADS and contracted MCOs. Any event reported through AIRS that involves the possible abuse, neglect, exploitation or fiduciary abuse of children that was not reported first to DCF is immediately reported to DCF by KDADS for further investigation.

In accordance with the KDADS HCBS Adverse Incidents Monitoring Standard Operating Procedure (SOP), KDADS Program Integrity and Compliance Specialists (PICS) or their designated back-up(s) are responsible for checking AIRS for any newly reported adverse incident. AIRS will automatically distribute adverse incident reports for review based on the issue, KDADS provider/program type (e.g., Behavioral Health, Older Americans Act, Senior Care Act, HCBS Waiver), and county location of the incident. If data was entered incorrectly, the KDADS PICS must correct any errors, and re-route the review to the appropriate KDADS party. This process will occur within one business day of receipt of an adverse incident report.

If AIRS does not auto assign the adverse incident, the KDADS PICS will review the adverse incident report and assign it appropriately within AIR. If the member requires protective services intervention or review, the PICS will immediately notify and forward the adverse incident report to (DCF) for further investigation.

If an Adverse Incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in each of the HCBS waivers. DCF must notify KDADS outlining DCF’s determination for the incident within five business days of the date of DCF determination, in accordance with the DCF Policy and Procedure Manual (Chapter 10320) and as defined in KSA 39-1433/38-2226.

For all submitted AIR reports, PICS first review AIRS adverse incident report information to determine if there is any indication of criminal activity and report any instances to law enforcement. If it is determined that there is suspected for Abuse, Neglect, Exploitation or Fiduciary Abuse, the KDADS PICS report immediately to DCF. Any areas of vulnerability would be identified for Additional training and assurance of education. PICS determine if the adverse incident report is screened in, screened out, or requires additional follow-up. Even for those incidents referred to DCF,

PICS document the incident and notify the participant's MCO of the incident.

Within one business day of receiving an AIR report, KDADS PICS will determine the level of severity for each screened in adverse incident reported in AIRS, and will assign a level of severity. Within one business day of a determination of the severity level PICS will notify the participant's MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up. KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member's Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP.

- The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. Per PPS policy number 1521, reports assigned for Abuse/Neglect concerns shall be assigned with either a same day or 72-hour response time. Reports assigned as Non-Abuse/Neglect Family in Need of Assessment (NAN FINA) are assigned a response time per PPS policy number 1670.
PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. KDADS assigns the report to the participant's managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

- The entity that is responsible for conducting investigations and how investigations are conducted:

DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

Review and Follow-up for Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children.

1. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF, if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services.
2. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS.
3. The report will not be assigned for further assessment or may be screened out after acceptance if the following apply:
a. The report does not meet the criteria for further assessment per DCF PPS Policy and Procedure Manual;
b. The event has previously been investigated;
c. DCF does not have the statutory authority to investigate;
d. Unable to locate family.
4. Not all reportable events require remediation; DCF shall determine which reportable events will result in remediation.

The process and timeframes for informing the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results includes:

Notice of Department Finding per DCF PPS Policy Number 2540:
The Notice of Department Finding for reports is PPS 2012. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.

All case decisions/findings shall be staffed with the CPS Supervisor/designee and a finding shall be made within thirty (30) working days of receiving the report. DCF sends the Notice of Department Finding to relevant persons who have a need to know of the outcome of an investigation of child abuse/neglect on the same day, or the next business day, of the case finding decision.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

- The state entity or entities responsible for overseeing the operation of the incident management system:

Kansas Department for Children and Families (DCF) is responsible for overseeing the reporting of and response to all reportable events related to Abuse, Neglect, Exploitation and Fiduciary Abuse. DCF maintains a database of all reportable events and transfers pertinent information from the database to AIRS.

KDADS is the entity responsible for overseeing the operation of the web-based adverse incident management system called AIRS, and responding to incidents reported in AIRS.

- The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

The KDADS Program Integrity Manager will, on a monthly basis, provide an AIR System Reconciliation Report to DCF-APS and CPS, which includes the number of all incidents KDADS received from each entity in the reported month. The purpose of this report is to verify all incidents reported to DCF-APS and CPS that require KDADS review were subsequently provided to KDADS. KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

The KDADS Program Quality Management Specialists review statewide trend analysis from AIR system aggregate-level reports across all MCOs and determine how the overall number of adverse incidents compares to previous reports. For each MCO, and across all MCOs, the Program QMS Program Manager will determine if there is a pattern in the number and percentage of adverse incidents and the potential driving forces. Based on these trends, favorable outcomes will be promoted and trends with the potential to negatively impact the program or members will be remediated. KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

- The frequency of oversight activities:

In accordance with the KDADS HCBS Adverse Incident Monitoring SOP, KDADS PICS are responsible for monitoring AIRS on an ongoing basis, and identifying adverse events that require follow-up investigation or remediation within one business day of receiving the report through AIRS. KDADS conducts reviews on a quarterly basis to determine that participants have received education from their MCO on their ability and freedom to prevent or report information about Abuse, Neglect, Exploitation or Fiduciary Abuse in accordance with KDADS HCBS Adverse Incident Reporting and Management Policy and KDADS Adverse Incident Monitoring SOP.
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1. Each MCO shall submit a monthly electronic report to KDADS Program Integrity which captures the following:
a. Performance data on each health and welfare performance measure as identified in each HCBS waiver.
b. Trend analysis by each HCBS waiver health and welfare performance measure.
c. Trend analysis on each type of adverse incident as defined in the KDADS HCBS Adverse Incident Monitoring SOP.
d. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
e. Remediation efforts by type of each adverse incident.

2. KDADS shall review MCO monthly reports containing performance data, trend analysis and remediation efforts, and shall conduct a random sampling of MCO (quarterly) records to determine the following:
a. Whether MCOs are taking adequate action to resolve and prevent adverse incidents.
b. How long it takes for an adverse incident to be resolved after becoming aware of an adverse incident or receipt of an adverse incident report.
c. Whether a Corrective Action Plan (CAP) is needed for the MCO to resolve identified deficiencies. Each CAP will be assigned a level of severity in accordance with KDADS Adverse Incident Monitoring Policy and KDADS Adverse Incident Monitoring SOP:
i. Level 1 – Deficiencies that are administrative in nature or related to reporting that have no direct impact on service delivery.
ii. Level 2 – Deficiencies that have the potential to impact the health, safety, or welfare of the member, or the ability to receive or retain services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

•Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraints. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

• Methods for detecting use of restraint and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out (unsubstantiated) or screened in (substantiated). DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

A finding of “screened in” is given to reports that meet the statutory requirements for a DCF investigation, while “screened out” does not meet the statutory requirements for a DCF investigation. All screened out (unsubstantiated) and screened in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff. An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.
All DCF determinations received by KDADS (screened in and screened out) are considered screened in adverse incidents by KDADS and are entered into the AIR system by KDADS for remediation and follow-up. The DCF determination informs KDADS’ on the appropriate investigation and remediation steps that should be taken by the MCOs. The significance of the DCF determination of screened in or out status is that, DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.
For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up.

• How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:
1) AIR performance data on each health and welfare performance measure as identified in each HCBS waiver
2) Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.)
3) Trend analysis on each adverse incident
4) Remediation efforts by health and welfare performance measure as identified in each HCBS waiver
5) Remediation efforts by each adverse incident

• The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

• The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:
• Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents
• Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident
• Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

•Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restrictive interventions. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

• Methods for detecting the use of restrictive interventions and ensuring that all applicable state requirements are followed:

All adverse incidents (including all unauthorized use of restrictive interventions) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out (unsubstantiated) or screed in (substantiated). DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

All DCF determinations received by KDADS (screened in and screened out) are considered screened in adverse incidents by KDADS and are entered into the AIR system by KDADS for remediation and follow-up. The DCF determination informs KDADS' on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes "screened in" classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

• How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3. Trend analysis on each adverse incident.
4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5. Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened-in and screened-out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

• The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

• The frequency of oversight:

Oversight is ongoing, as indicated in the AIR System Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1. Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2. Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3. Following up with MCOs to identify systemic concerns and address them through the implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of restrictive intervention. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restrictive intervention) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out (unsubstantiated) or screened-in (substantiated). DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.
All DCF determinations received by KDADS (screened in and screened out) are considered screened in adverse incidents by KDADS and are entered into the AIR system by KDADS for remediation and follow-up. The DCF determination informs KDADS' on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes "screened in" classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

- How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3. Trend analysis on each adverse incident.
4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5. Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

- The frequency of oversight:

Oversight is ongoing, as indicated in the AIR System Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1. Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2. Monitoring the time, it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3. Following up with MCOs to identify systemic concerns and address them through the implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures D=Number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexpected deaths for which the appropriate follow-up measures were taken N=Number of unexpected deaths for which the appropriate follow-up measures were taken D=Number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews and Customer Interviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames D=Number of participants' reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures N=Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures D=Number of reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical incident management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unauthorized uses of restrictive interventions that were appropriately reported N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who have a disaster red flag designation with a related disaster red flag designation with a related disaster backup plan N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%

☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who received physical exams in accordance with State policies, N=Number of HCBS participants who received physical exams in accordance with State policies, D=Number of HCBS participants

whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare Managed Care organizations(MCOs)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful consumer feedback on the HCBS program. The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE's Long-Term Care Committee and interagency monitoring team(s).
In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor's systems as well as the Managed Care Organizations' systems. On a routine basis, KDADS' Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency's critical incident management system. KDADS worked with Adult Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS' Quality Management Specialists collect data, aggregate it, analyze it and provide information regarding discrepancies and trends to Program staff, Quality staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other**	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Specify: KanCare Managed Care Organizations (MCOs)	Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with Hewlett Packard (HP) to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and HP staff to generate recommended systems changes, which are then monitored and analyzed by HP and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Operating Agency has developed Quality Management staff and an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and to identify areas for improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ◉ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:
a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) The Kancare MCO is responsible for conducting post payment review for payments. The MCO monitors claims payments to ensure members are receiving the services defined in the plan of care.If there were concerns regarding a provider's billing practice, the MCO would conduct a claims audit which includes requesting provider documentation for services rendered. The MCO has ongoing audits for all services rendered to waiver members. Monthly MCO meetings occur with the MCOs, KDADS and KDHE staff and leadership. At these meetings, any concerns are shared, and follow-up is performed. Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program -are part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the interagency monitoring team(s), an important part of the overall state's KanCare Quality Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.
The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:
a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
c. Report immediately to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the

possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
(1) Oversight of the program integrity function under this contract;
(2) Liaison with the State in all matters regarding program integrity;
(3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
(4) Liaison with Kansas' MFCU;
(5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

The State makes payment to the MCO based on the eligibility category assigned by the eligibility system, KEES. The eligibility file is loaded on a nightly basis to the MMIS. Any changes that occur to the participant's eligibility are made in KEES, sent to the MMIS, and updated nightly. Capitation payments are made to the MCOs' retrospectively. The reconciliation process in the MMIS with the 834 will catch the capitation error and recoup against the MCO payment.

Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. Only Native American populations can opt out of managed care.
These claims could be pulled into a SURS audit. Audits could be conducted by SURS or by a federal entity such as PERM. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider is flagged as an outlier or for questionable billing practices.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were concerns regarding a provider's billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered.

The Legislative Division of Post Audit (LPA) is the non-partisan audit arm of the Kansas Legislature.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
State data systems

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D= Total number of provider claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
State data system

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***

☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS throughout the five year renewal cycle. N=number of payment rates that were certified to be actuarially sound by the State' actuary and approved by CMS D=Total number of capitation (payment) rates

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
State data systems

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The state established an inter-agency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the inter-agency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *KanCare MCOs contracting with Kansas.*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ ***No***

◉ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes, and other relevant environmental and financial factors. The floor rates were last reviewed and revised effective 7/1/19 per State Policy when a rate adjustment was made effective. The adjustment was made available through legislative appropriation.

Capitation rates are based on actuarial analysis of historical data for all HCBS program services. These rates are set by the state's contracted actuary and are based on historical claims and utilization. The state provides all appropriate data to the Actuary for the rate setting process. The Medicaid agency then sets the actuarial certified capitation rate within the range and the capitation rates are approved by CMS. The MCO's are responsible for trending costs and demonstrating financial experience going forward. Based on the data collected, the MCO may request the State's review for cost adjustments.

The State does not currently have a set timeframe for regular reviews of the FFS rates for Waiver services. However, there are periodic checks of the rates and utilization for each of the services on the waiver. The State has leveraged and will continue to leverage, multiple sources to assist in researching the adequacy of our rates. This would include strategies such as engaging with a consulting group to provide a rate study of surrounding states to benchmark where Kansas rates rank. The State also periodically requests that the MCOs review rates for similar services in other markets that they serve. Additionally, the State has open lines of communication with various provider groups and welcomes research performed by such groups as another data point. The goal of these studies is to ensure that the rates for waiver services are sufficient to encourage providers to continue serving the waiver population, thus maintaining network adequacy. The agency has the discretion to set and adjust the rates as they deem necessary; if the agency determines that a rate change is necessary, they would write a policy to change the fee schedule accordingly. Changing rates do not require legislative authority; however, since the legislature is the only body that can appropriate funds, the agency would need to request funding from the legislature to increase its budget to account for the increased spend associated with a rate change.

The state operating agency, in collaboration with the Medicaid agency, is responsible for rate determination and oversight of the process to ensure actuarially sound methods, including historical claims, are used to determine service rates. Under KanCare, the State sets the floor HCBS service rates, which serve as the minimum MCOs are required to pay providers. It should be noted that funding for rate increases requires legislative appropriation in Kansas

The Operating Agency ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt-out from Managed Care. In the event, there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available.

The Operating Agency ensures public comment is available as rate adjustments are dependent on legislative appropriation which each year provides opportunity for public and stakeholder feedback and comments on rates during each legislative process.

FFS rates are publicly available via State Bulletins via the State's KMAP website.

The KanCare program solicited public input when the program was developed which included the State setting the floor for service rates.

Waiver participants can obtain information about reimbursement rates for individual services by contacting their assigned MCO.

FFS rates can be found via State Bulletins via the State's KMAP website."
An example, the notice for adjusted rates effective July 1, 2019 rates are included in the bulletin below.

https://www.kmap-state-ks.us/Documents/Content/Bulletins/19113%20-%20HCBS%20-%202019_Rate_Increase.pdf

Stakeholders can locate public notices and update the waiver accordingly via:

https://kdads.ks.gov/commissions/home-community-based-services-(hcbs)/proposed-waiver-renewals

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Claims for services are submitted to the MCOs directly from waiver provider agencies or from Financial Management Service (FMS) agencies for those individuals self-directing their services. All claims are either submitted through the EVV system, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Claims for services required in the EVV system are generated from that system. Capitated payments in arrears are made only when the consumer was eligible for the Medicaid waiver program during the month. Claims furnished on an FFS basis is processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. Only Native American populations can opt out of managed care

The Electronic Visit Verification (EVV) system is used to document time and attendance of service delivery. It captures and verifies worker's identity, location, service time, type of service and Medicaid recipient. The system has the capability to generate a comprehensive report to monitor worker activity, claims submission and claims exceptions, including alerts of potential duplicate claims. Exceptions identified must be addressed prior to submitting HIPPA compliant claims as part of front end billing to managed care organizations for payment. When an integrated scheduler is used, the system has the capability to receive real-time alerts for late and missed visits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through the Kansas Eligibility Enforcement System (KEES). The state also is requiring the MCOs to utilize the State's contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the consumer's plan of care detailing authorized services. All mandated services must be billed through the EVV system. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1.Individuals (participants) must be determined to have met the program's level of care criteria and Medicaid eligible prior to starting services.

Services delivered that are reimbursed through Medicaid payments are only for services that are authorized on the approved Plan of Care and within the service limitations written into the service descriptions.

These claims could be pulled into a SURS audit. Audits could be conducted by SURS. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider is flagged as an outlier or for questionable billing practices. The State performs various reviews and audits of the MCOs regarding HCBS including but not limited to report reviews, quarterly case file reviews, annual reviews, provider qualification reviews to determine whether services were provided.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post-payment FFS claims audit. If there were concerns regarding a provider's billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered

The KanCare MCO is responsible for conducting a post-payment review for payments. The MCO monitors claims payments to ensure members are receiving the services defined in the plan of care. If there were concerns regarding a provider's billing practice, the MCO would conduct a claims audit which includes requesting provider documentation for services rendered.
The MCO has ongoing audits for all services rendered to waiver members. Monthly MCO meetings occur with the MCOs, KDADS and KDHE staff and leadership. At these meetings, any concerns are shared, and follow-up is performed.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

There have been no FFS claims outside of the capitated rate for the last 5 years and the state does not anticipate there will be FFS claims in future years.

Only Native American populations can opt-out of managed care.
FFS providers have the option to be paid via a check or through EFT. Payment is made based on the provider's preference.
All other claims paid outside of the MMIS system are paid to the MCOs through a per member per month capitated payment. The claim is received and processed through the MMIS Claims Engine. The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment."
The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions

that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.
Only Native American populations can opt-out of managed care.
In the event an FFS participant chose to Self-Direct their services; those services would be provided by an FMS provider that is enrolled with the Medicaid Program that would act as a limited fiscal agent between the state and the participant/employer.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that

the state or local government providers furnish:

In the event there was an FFS opt out and a local government entity was a service provider, the local entity would be reimbursed the same amount as a private provider

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ( ) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- (●) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Anyone received their services through FFS, the provider would retain 100% of the amount claimed.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ◉ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these***

plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the operating agency. The non-federal share of the waiver expenditures is directly expended by KDADS. Both capitated rates and FFS Medicaid claim payments are processed by the State's fiscal agent through the MMIS using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. DHCF-KDHE draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on FFS claims and capitation payments in the KanCare program.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

  Check each that applies:

  - [ ] ***Appropriation of Local Government Revenues.***

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] ***Other Local Government Level Source(s) of Funds.***

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home***

of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

When establishing reimbursement rates as described in Appendix I-2,a, no expenses associated with room and board are considered.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols.*

4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	16514.59	9847.00	26361.59	30678.00	3716.00	34394.00	8032.41
2	16514.59	9847.00	26361.59	30678.00	3716.00	34394.00	8032.41
3	16514.59	9847.00	26361.59	30678.00	3716.00	34394.00	8032.41
4	16514.59	9847.00	26361.59	30678.00	3716.00	34394.00	8032.41
5	16514.59	9847.00	26361.59	30678.00	3716.00	34394.00	8032.41

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	6898	6898
Year 2	6898	6898
Year 3	6898	6898
Year 4	6898	6898
Year 5	6898	6898

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) estimate is derived from the unduplicated participants and days of waiver enrollment from the approved CMS-372 reports for calendar year 2016. The ALOS was projected by dividing 2,182,347 (the days of waiver enrollment) by 6,898 (unduplicated participants). The projected average length of stay for this renewal is 316.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D is estimated by using actual MCO encounter data from the Medicaid Management Information System (MMIS) of the Home and Community Based Services waiver service cost and utilization for the Physical Disability waiver participants. Actual MCO encounter payments were utilized in order to estimate the state cost of Factor D as part of an all-inclusive capitated payment. The MCO encounter data was used to establish the estimated number of users and utilization which was averaged over the three-year period. The state utilized the most recent cost per unit data at the time the Waiver renewal was prepared to ensure most current cost data was recognized. Factor D' estimates do not include the cost of prescribed drugs that are furnished to dual-eligible under the provisions of Medicare Part D. This is not a Medicaid cost, and it is not paid through the MMIS.

For the waiver renewal period, there is no annual trending applied to the unit cost for Factor D. The State does not currently anticipate that there will be a significant change in rates over the next five years as the rate adjustments are subject to legislative appropriation. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is estimated by using actual MCO encounter data from the Medicaid Management Information System (MMIS) of the Home and Community Based Services waiver service cost and utilization for the Physical Disability waiver participants. Actual MCO encounter payments were utilized in order to estimate the state cost of Factor D as part of an all-inclusive capitated payment. The MCO encounter data was used to establish the estimated number of users and utilization which was averaged over the three-year period. The state utilized the most recent cost per unit data at the time the Waiver renewal was prepared to ensure most current cost data was recognized.

In Kansas Factor G' has historically been greater than D'. This is primarily attributed to the costs of hospice services being included as part of the State Plan G' services. Approximately 50% of G' costs are attributed to hospice services

Based on analysis of actual MCO encounter claims, the estimates for D' for the prior period were over estimated by approximately $500. The actual average for CY15 through CY17 was approximately $2,700 while estimates were around $3,200.

For the waiver renewal period, there is no annual trending applied to the unit cost for Factor D'. The State does not currently anticipate that there will be a significant change in rates over the next five years as the rate adjustments are subject to legislative appropriation.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is estimated by utilizing actual MCO encounter data from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of the nursing facility utilization for nursing facility participants which is trended with the most current cost information.

For the waiver renewal period, there is no annual trending applied to Factor G. The State has not included any assumptions that there will be a significant change in institutional costs over the next five years for this population. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

The State cannot use the CMS-372 reports to estimate Factor G because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs. The State used encounter data from the MMIS as the base data in the derivation of Factor G to most accurately represent the cost associated with those served in the institutional equivalent.

For the waiver renewal period, there is no trending applied to Factor G. The State has not included any assumptions that there will be a significant change in institutional costs over the next five years for this population.

The State cannot use the CMS-372 reports to estimate Factor G, because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs.The State used encounter data from the MMIS as the base data in the derivation of Factor G to most accurately represent the cost associated with those served in the institutional equivalent.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is estimated by utilizing MCO encounter data from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of utilization and persons served for all other Medicaid services furnished while the individual is institutionalized. The averages are trended with most current cost data.

For the waiver renewal period, there is no annual trending applied to Factor G'. The State does not currently anticipate that there will be a significant change in rates over the next five years. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

Factor G' estimates do not include the cost of prescribed drugs that are furnished to dual eligible under the provisions of Medicare Part D. This is not a Medicaid cost, and it is not paid through the MMIS.

The State cannot use the CMS-372 reports to estimate Factor G', because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs. The State used MCO encounters data from the MMIS as the base data in the derivation of Factor G' to most accurately represent the cost associated with those served in the institutional equivalent

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Personal Care Services	
Financial Management Services	
Assistive Services	
Enhanced Care Service	

Waiver Services	
Home-Delivered Meals Service	
Medication Reminder Services	
Personal Emergency Response System and Installation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							84768014.12
Personal Services - Agency-Directed	☒	15 minutes	1611	3316.57	3.40	18166180.52	
Personal Services - Self-Directed	☒	15 minutes	4851	4669.90	2.94	66601833.61	
Financial Management Services Total:							6119288.20
Financial Management Services	☒	1 month	4911	9.69	128.59	6119288.20	
Assistive Services Total:							331713.48
Assistive Services	☒	1 purchase	123	1.28	2106.92	331713.48	
Enhanced Care Service Total:							17299873.87
Enhanced Care Service	☒	1 unit	1164	231.43	64.22	17299873.87	
Home-Delivered Meals Service Total:							4166041.19
Home-Delivered Meals Service	☒	1 meal	1998	343.51	6.07	4166041.19	
Medication Reminder Services Total:							63774.02
Medication Reminder	☒	1 month	3	1.00	31.88	95.64	
Medication Reminder/Dispenser	☒	1 month	265	7.88	29.62	61852.48	
Medication	☒					1825.90	

GRAND TOTAL:	113917644.39
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	6898
Factor D (Divide total by number of participants):	16514.59
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Reminder/Dispenser/Installation		1 installation	62	1.00	29.45		
Personal Emergency Response System and Installation Total:							**1168939.50**
Personal Emergency Response System	☒	1 month	3205	8.58	41.29	**1135429.58**	
Personal Emergency Response System Installation	☒	1 installation	584	1.00	57.38	**33509.92**	

GRAND TOTAL:	**113917644.39**
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**6898**
Factor D (Divide total by number of participants):	**16514.59**
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							**84768014.12**
Personal Services - Agency-Directed	☒	15 minutes	1611	3316.57	3.40	**18166180.52**	
Personal Services - Self-Directed	☒	15 minutes	4851	4669.90	2.94	**66601833.61**	
Financial Management Services Total:							**6119288.20**
Financial Management Services	☒	1 month	4911	9.69	128.59	**6119288.20**	
Assistive Services Total:							**331713.48**
Assistive Services	☒	1 purchase	123	1.28	2106.92	**331713.48**	
Enhanced Care Service Total:							**17299873.87**

GRAND TOTAL:	**113917644.39**
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**6898**
Factor D (Divide total by number of participants):	**16514.59**
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Care Service	☒	1 unit	1164	231.43	64.22	17299873.87	
Home-Delivered Meals Service Total:							4166041.19
Home-Delivered Meals Service	☒	1 meal	1998	343.51	6.07	4166041.19	
Medication Reminder Services Total:							63774.02
Medication Reminder	☒	1 month	3	1.00	31.88	95.64	
Medication Reminder/Dispenser	☒	1 month	265	7.88	29.62	61852.48	
Medication Reminder/Dispenser/Installation	☒	1 installation	62	1.00	29.45	1825.90	
Personal Emergency Response System and Installation Total:							1168939.50
Personal Emergency Response System	☒	1 month	3205	8.58	41.29	1135429.58	
Personal Emergency Response System Installation	☒	1 installation	584	1.00	57.38	33509.92	

GRAND TOTAL:	113917644.39
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	6898
Factor D (Divide total by number of participants):	16514.59
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							84768014.12
Personal Services - Agency-Directed	☒	15 minutes				18166180.52	

GRAND TOTAL:	113917644.39
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	6898
Factor D (Divide total by number of participants):	16514.59
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1611	3316.57	3.40		
Personal Services - Self-Directed	☒	15 minutes	4851	4669.90	2.94	66601833.61	
Financial Management Services Total:							6119288.20
Financial Management Services	☒	1 month	4911	9.69	128.59	6119288.20	
Assistive Services Total:							331713.48
Assistive Services	☒	1 purchase	123	1.28	2106.92	331713.48	
Enhanced Care Service Total:							17299873.87
Enhanced Care Service	☒	1 unit	1164	231.43	64.22	17299873.87	
Home-Delivered Meals Service Total:							4166041.19
Home-Delivered Meals Service	☒	1 meal	1998	343.51	6.07	4166041.19	
Medication Reminder Services Total:							63774.02
Medication Reminder	☒	1 month	3	1.00	31.88	95.64	
Medication Reminder/Dispenser	☒	1 month	265	7.88	29.62	61852.48	
Medication Reminder/Dispenser/Installation	☒	1 installation	62	1.00	29.45	1825.90	
Personal Emergency Response System and Installation Total:							1168939.50
Personal Emergency Response System	☒	1 month	3205	8.58	41.29	1135429.58	
Personal Emergency Response System Installation	☒	1 installation	584	1.00	57.38	33509.92	

GRAND TOTAL:	113917644.39
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	6898
Factor D (Divide total by number of participants):	16514.59
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							**84768014.12**
Personal Services - Agency-Directed	☒	15 minutes	1611	3316.57	3.40	**18166180.52**	
Personal Services - Self-Directed	☒	15 minutes	4851	4669.90	2.94	**66601833.61**	
Financial Management Services Total:							**6119288.20**
Financial Management Services	☒	1 month	4911	9.69	128.59	**6119288.20**	
Assistive Services Total:							**331713.48**
Assistive Services	☒	1 purchase	123	1.28	2106.92	**331713.48**	
Enhanced Care Service Total:							**17299873.87**
Enhanced Care Service	☒	1 unit	1164	231.43	64.22	**17299873.87**	
Home-Delivered Meals Service Total:							**4166041.19**
Home-Delivered Meals Service	☒	1 meal	1998	343.51	6.07	**4166041.19**	
Medication Reminder Services Total:							**63774.02**
Medication Reminder	☒	1 month	3	1.00	31.88	**95.64**	
Medication Reminder/Dispenser	☒	1 month	265	7.88	29.62	**61852.48**	
Medication Reminder/Dispenser/Installation	☒	1 installation	62	1.00	29.45	**1825.90**	
Personal Emergency Response System and Installation Total:							**1168939.50**
Personal Emergency Response System	☒	1 month	3205	8.58	41.29	**1135429.58**	
Personal Emergency Response System Installation	☒	1 installation	584	1.00	57.38	**33509.92**	

GRAND TOTAL:	**113917644.39**
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**6898**
Factor D (Divide total by number of participants):	**16514.59**
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							**84768014.12**
Personal Services - Agency-Directed	☒	15 minutes	1611	3316.57	3.40	**18166180.52**	
Personal Services - Self-Directed	☒	15 minutes	4851	4669.90	2.94	**66601833.61**	
Financial Management Services Total:							**6119288.20**
Financial Management Services	☒	1 month	4911	9.69	128.59	**6119288.20**	
Assistive Services Total:							**331713.48**
Assistive Services	☒	1 purchase	123	1.28	2106.92	**331713.48**	
Enhanced Care Service Total:							**17299873.87**
Enhanced Care Service	☒	1 unit	1164	231.43	64.22	**17299873.87**	
Home-Delivered Meals Service Total:							**4166041.19**
Home-Delivered Meals Service	☒	1 meal	1998	343.51	6.07	**4166041.19**	
Medication Reminder Services Total:							**63774.02**
Medication Reminder	☒	1 month	3	1.00	31.88	**95.64**	
Medication Reminder/Dispenser	☒	1 month	265	7.88	29.62	**61852.48**	
Medication Reminder/Dispenser/Installation	☒	1 installation	62	1.00	29.45	**1825.90**	
Personal Emergency Response System and Installation Total:							**1168939.50**
Personal Emergency Response System	☒	1 month	3205	8.58	41.29	**1135429.58**	
Personal Emergency Response System Installation	☒	1 installation	584	1.00	57.38	**33509.92**	

GRAND TOTAL:	**113917644.39**
Total: Services included in capitation:	113917644.39
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**6898**
Factor D (Divide total by number of participants):	**16514.59**
Services included in capitation:	16514.59
Services not included in capitation:	
Average Length of Stay on the Waiver:	316