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:
Technology Assisted Waiver

C. Waiver Number:KS.4165
Original Base Waiver Number: KS.40165.

D. Amendment Number:KS.4165.R06.07

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

Approved Effective Date of Waiver being Amended: 08/01/18

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*):

Technology Assisted 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.40165
Waiver Number:KS.4165.R06.07
Draft ID: KS.007.06.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 08/01/18
Approved Effective Date of Waiver being Amended: 08/01/18

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:

○ **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 for this waiver is to provide eligible Kansans age 0 through 21 who would otherwise require institutionalization in a hospital setting a choice to receive needed services in their home and community. The goals and objectives of this waiver is to provide individuals who are medically fragile and require life-sustaining medical technology the opportunity to access long term care services intended to assist individuals in managing their healthcare limitations in order to progress towards independence, productivity, and community integration and inclusion. The waiver is intended to provide supports and services to meet the medical needs of the individuals and will be provided in a manner that affords the same dignity and respect would be provided to any person who does not have a disability.

The Program requires each participant receiving either agency-directed, participant-directed, or both agency and participant directed waiver services have a Person-Centered Service Plan that identifies at a minimum: 1) Primary Diagnosis; 2) Technology (medical) needs; and 3) an Person-Centered Service Plan which identifies frequency, scope and duration of longterm community medical support services. Each waiver participants will have a Person-Centered Service Plan. The Person-Centered Service Plan is developed by licensed medical professionals qualified to assess the healthcare needs of the individual. The Person-Centered Service Plan will address issues and actions related to individual goals and objectives, access to (formal or informal) services, services to be provided, frequency, delivery method and providers of each of the services. All services will be furnished according to the written Person-Centered Service Plan.

The Person-Centered Service Plan will be developed and provided as a part of a comprehensive package of services offered by KanCare health plans (Managed Care Organizations), and will be paid as part of a capitated rate. The health plans are responsible for assigning a nurse case manager/ care coordinator who will conduct a comprehensive needs assessment and develop a Person-Centered Service Plan that includes both state plan services and, as appropriate, the TA waiver services listed below.

Services available through the TA waiver under KanCare are: specialized medical care; personal care services (agency directed and self-directed); financial management services; health maintenance monitoring; home modification; intermittent intensive medical care; and medical respite care services. Case management services will be provided by KanCare health plans.

With this renewal, TA waiver participant will receive an initial assessment and reassessment for continued level of care eligibility determination utilizing a standardized Medical Assistive Technology Level of Care (MATLOC) assessment instrument. The initial level of care eligibility and six months reassessments will be completed by contracted MATLOC Eligibility Specialists (MES).

The move to integrate TA waiver services into KanCare does not diminish the waiver’s focus on independence, productivity, community integration and inclusion, as well as participant-driven services. Participants will continue to have a choice between participant-directed (self-directed), or they may choose agency directed (non-self-directed) services.

Programmatic oversight and control of the waiver is provided by the Kansas Department for Aging and Disability Services(KDADS) and Kansas Department of Health and Environment (KDHE), SSMA.

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: Senior Manager,Contracts and Fiscal Agent Operations

Agency: Kansas Department of Health and Environment

Address: 900 SW Jackson,

Address 2: Suite 900 North

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: Heydon

First Name: Michele

Title: Program Manager

Agency: Kansas Department for Aging and Disability Services

Address: 503 S. Kansas

Address 2:

City: Topeka

State: **Kansas**

Zip: 66603

Phone: (785) 296-0935 **Ext:** ☐ **TTY**

Fax: (785) 296-0256

E-mail: Michele.Heydon@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:

Kurt.Weiter@ks.gov

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:

There will be no negative impact on waiver enrollees.

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):

N/A

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/Community Services and Programs Commission

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 will 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. This process includes a face to face meeting with KDHE staff.

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. In addition, under the KanCare program, as the HCBS waiver programs merge into comprehensive managed care, 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 identified in part (a) above. The key component of that collaboration will be through the KanCare interagency monitoring team, an important part of the overall state's KanCare Quality Improvement 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.

The services in this waiver are part of the state's KanCare comprehensive 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) will be guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the interagency monitoring team, which will 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 will be on a quarterly basis. While continuous monitoring will be conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure. Kansas has amended the KanCare QIS to include the concurrent HCBS waiver connections, and will be seeking CMS approval of amendments of the HCBS waivers that embed the KanCare QIS 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.:*

Contracted independent level of care eligibility assessors will be utilized to perform the following administrative functions on behalf of the Medicaid agency and/or operating agency:
• Disseminate waiver information to potential consumers
• Conduct initial eligibility assessment, reassessments and ongoing evaluation activities for current and potential waiver participants
• Assess for expedited service needs
• Assist waiver participants with Medicaid financial applications
• Provide options counseling
The state's contracted Managed Care Organizations conduct Person-Centered Service Plan development and related service authorization, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

○ **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:

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/ Community Services and Programs Commission

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:

Kansas Department for Aging and Disability Services/ Community Services and Programs Commission
Contracted entities, including both contracted entities/providers and the state's contracted KanCare managed care organizations, are monitored through the State's KanCare Quality Improvement Strategy (QIS), 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. All functions delegated to contracted entities are included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process is KDHE and KDADS collaboration, which includes HCBS waiver management staff from 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 and the KanCare MCOs and independent assessment contractors.
The KanCare Quality Improvement Strategy and interagency agreements will ensure that the entities contracting with KDADS (the Waiver Operating Agency) 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 will monitor KDADS' development of operational processes, and will collaborate with KDADS to ensure that appropriate administrative oversight components are specified in those processes. Through existing KDHE policy review processes and periodic KDHE LTC meeting updates/reports, KDHE will ensure implementation of the new operational processes to include KDHE monitoring of quality measures via quarterly and ad hoc reporting by KDADS to KDHE, as well as periodic sample review by KDHE.
KDADS and KDHE conducts quarterly record reviews to assess the contracted entities performance and to ensure HCBS programs are being administered in accordance with the waiver requirements. In addition to the review of contracted entities, the operating agency conducts consumer surveys to gather data on access to services and effectiveness of services delivery. Oversight will be conducted on a minimum quarterly and more frequently if necessary. In instances where the operating agency is primarily responsible for conducting the assessment, the operating agency will analyze and compile the contracted entities performance results and report the findings and summaries to the Medicaid agency.
KDHE will monitor KDADS' development of operational processes, and will collaborate with KDADS to ensure that appropriate administrative oversight components are specified in those processes. Through existing KDHE policy review processes and periodic KDHE LTC meeting updates/reports, KDHE will ensure implementation of the new operational processes to include KDHE monitoring of quality measures via quarterly and ad hoc reporting by KDADS to KDHE, as well as periodic sample review by KDHE.

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
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 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:
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:

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 reviewed 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:
Number of waiver amendments and renewals

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 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:
Meeting minutes

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** 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 policy changes submitted to the State Medicaid Agency prior to implementation by the Operating Agency. D= Number of policy changes.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Presentation of waiver policy changes

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.

Not Applicable

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.
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 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**
☐ **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.

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)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☒	Medically Fragile	0	21	☐
	☒	Technology Dependent	0	21	☐
☐ 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:

A technology assisted and medically fragile individual age 0 through 21 years who is chronically ill or medically fragile and is dependent upon a ventilator or medical device to compensate for the loss of vital body function and requires substantial and ongoing daily care by a nurse, comparable to the level of care provided in a hospital setting, in order to avert death or further disability.

Furthermore, the individual was hospitalized, or at imminent risk of hospitalization, whose illness or disability, in the absence of home care services, would require admission to, or prolonged stay in a hospital.

Individuals must be determined functionally eligible for the program utlizing the MATLOC instrument that is established for determininf the person's medical technology dependency and the level of acuity needs for specific age group. The criteria are as follows:

0-21 yrs(Technology score=50); or
0-5 yrs(Technology score=25, Acuity score=20); or
6-21 yrs(Technology score=25, Acuity score=30)

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:

TA waiver recipients who are approaching their 22nd birthday will transition to the HCBS Physically Disabled (PD), Intellectual/ Developmental Disability(I/DD)or Traumatic Brain Injury (TBI)waiver provided the participant meets the established criteria and request to transition to other waiver services by the participant's 22nd birthday. Participants currently receiving waiver services will be assisted by his/her MCO Care Manager in the process of transitioning to other eligible waiver services or community resources.
The MCO Care Coordinator will assist participants by providing information regarding other programs and services available to the participant/family so that they are able to make an informed choice. MCO Care Coordinator will assist the participant/family in accessing the chosen waiver programs or services and work with other program or service coordinators in order to ensure a smooth transition. The transition is complete once the participant is established with the new services and the MCO Care Coordinator informs the TA Waiver Program Manager the participant has aged out of the program.
"The HCBS TA program manager shall communicate the start date as the waiver participant approaches his/her 22nd birth date and the new Person-Centered Service Plan costs to the EES Specialist (the Medicaid eligibility worker) on or before the effective date of transfer. The waiver participants Person-Centered Service Plan costs are paid by the HCBS-Technology Assisted waiver until the participant's 22nd birthday. Specifically for the 1931 group, who no longer meet the level of care eligibility criteria for the TA waiver will be assisted by his/her MCO Care Coordinator of choice to transition to other community services or waiver program for which he/she is eligible to receive."
In the event, the participant is assessed ineligible by the contracted independent assessor for the level of care as defined for TA waiver specific target group, the participant will be assisted by the MCO Care Coordinator to transition to an alternate waiver for which he/she is eligible or other community program and resources within 45 days after receiving the notice of action from KDADS.

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	543
Year 2	543
Year 3	543
Year 4	543
Year 5	543

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	
Year 2	
Year 3	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 4	
Year 5	

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	
Military Inclusion	
Temporary Institutional Stay	

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. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established TBI waiver criteria will be allowed to bypass the waitlist and access services.

Describe how the amount of reserved capacity was determined:

There are no data to support this 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

Waiver Year	Capacity Reserved
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 (10) 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. Participants that remain in the institution following the two month allotment will be terminated from the HCBS program. The participant can choose to reapply for services at a later date and will be reinstated if the participant meets program eligibility requirements or placed on a waiting list if applicable.

Describe how the amount of reserved capacity was determined:

This amount is a projected reserved capacity.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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:

To be eligible for the HCBS-TA Waiver, the individual must be chronically ill, medically fragile and is dependent upon a ventilator or medical device to compensate for the loss of vital body function and requires substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting. The individual must meet the level of care eligibility requirement for this waiver.
The waiver provides for the entrance of all eligible persons. Kansas does not expect to establish a waiting list.

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**
- [x] **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:

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)

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:

All allowable services and items are at the usual and customary rate of the provider unless otherwise noted. Excessive Quantities: For any item or service, quantities up to the normal industry standard are allowable unless specifically ordered by a medical practitioner.

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:

Level of care evaluations and reevaluations are performed by independent assessors or agency contracted with State of Kansas/ KDADS to perform this function effective 01/01/13.

○ **Other**

Specify:

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:

MATLOC Assessors must:

be an Advance Practice Registered Nurse; or Registered Nurse with bachelor's degree and two years of clinical experience in the nursing field.
* Hold a current license to practice in the capacity of nurse in the State of Kansas.
* submit a copy of current nursing license, degree and resume.
* MATLOC certified by KDADS and experience working with medical technology dependent children/ adults.
* adherence to KDADS MATLOC training and professional development requirements;
* MATLOC Assessors must be in compliance with the KDADS' Background Check Policy.
* must be a Medicaid enrolled provider or employees of a Medicaid enrolled provider
* Providers of this service may not provide direct services or provide direct services under a contracted provider of TA Waiver services.

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.

Kansas contracted independent level of care (LOC) eligibility assessors will provide an initial evaluation; at 6 months and as needed when technology needs changes.

The LOC criteria implemented for initial assessments of HCBS-Technology Assisted applicants is the same assessment conducted bi-annually at reassessment and as needed when medical needs changes.

A waiver participant continued eligibility for waiver services is contingent upon the individual meeting the level of care criteria.

Utilizing the Medical Assistive Technology Level of Care (MATLOC) instrument, the assessor will assess for level of care (LOC) eligibility and the MCO care coordinator will assess need for waiver services level, in example specialized nursing or attendant care. The assessment will provide scoring for each medical technology and care element depicting the functional eligibility and level of medical needs for the waiver participant.

The process for level of care(LOC) determination are as follows;

The assessor conducts the Level of Care (functional eligibility) assessment of the individual applying for waiver services within five(5) working days of the referral, an exception to the 5 working days may be granted by KDADS if requested by the individual, family or legal representative applying for waiver services or in the event the applicant is institutionalized at the time of the scheduled assessment.

Following an assessment of the individual's primary technology and nursing acuity, the individual is deemed eligible if the individual has met the target definition of technology assisted and the following criteria;

1) Technology Assisted LOC eligibility
   Age 0-21 years with a minimum technology score of (50) points, or
   Age 0 through 5 years with a minimum technology score of (25) points and a nursing acuity score of (20) points, or
   Age 6 through 21 years with a minimum technology score of (25) points and an acuity score of (30) points.
2) Participant is determined Medicaid eligible
3) Reviewed and approved by the physician

The Recommended Service Plan/Expedited Service Plan is used, in part, when children need to be discharged from the hospital with services in place before they can be released. Children’s Mercy often requires this in order to discharge the child. The Recommended Service Plan/Expedited Service Plan can have include waiver services. The Recommended Service Plan/Expedited Service Plan will be in place until the MCO Care Coordinator has their Person Centered Service Plan in place no later than fourteen working days from notification to the MCO of eligibility. The MCO Care Coordinator then conducts an in-person visit, completes their own assessment, and develops the Person-Centered Service Plan. The Care Coordinator will refer to the MATLOC instrument in addition to their organization’s needs assessment tool for a comprehensive evaluation of the participant’s care needs to develop a Person-Centered Service Plan.
The MCO assessment of service needs should supplement the MATLOC assessment and include the following components:
• Medical assisted technology needs;
• Attendant and skill nursing level of care needs;
• Comprehensive evaluation of the participant's health;
• Communication and social needs;
• Home and environment support needs;
• Availability of Informal and formal supports;
• General health needs, goals and personal preferences;
• Environmental, familial and social risk factors.
All these considerations and input from the participant/parent/legal guardian or legal representative assist the KanCare MCO entity in developing and coordinating the services appropriate to meet the participant's needs. All informal supports and non-waiver services are considered to assure non-duplication of waiver services.
The participant/parent/legal guardian or legal representative is the primary source of information. The KanCare MCO entity may contact other sources such as physicians, other health care providers, or family members to obtain necessary information for developing a Person-Centered Service Plan.
Quality management staff from KDADS Survey, Certification, and Credentialing conduct quarterly MCO record reviews as part of the overarching quality improvement strategy embedded within the waiver application. Separate metrics are in

place for measuring accurate and timely completion of the MATLOC functional assessment by the contracted assessing entity versus ensuring the MCO service plan meets the needs of the waiver participant.

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.

KDADS understands that hospitals do not share a specific assessment but take a collaborative approach to determine hospitalization for technology dependent children. Clinical judgment of each child's medical team is what determines admission to hospitals. Similarly, the MATLOC is the assessment used to determine the nursing acuity of the waiver participant which then correlates to the amount of time needed to support their nursing needs. The same approach is used in the acute care hospital setting. An assessment is done and the nursing care plan is then correlated to the assessment findings. Under the waiver performance measures that pertain to service planning, KDADS quality review staff monitor service plans to ensure individuals are supported with services of an appropriate type, scope, amount, duration, and frequency to avoid acute hospitalization.

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 process for Level of Care reevaluation is the same as the process for the initial Level of Care eligibility evaluation. The Medical Assistive Level of Care (MATLOC) instrument is utilized to assess whether a participant continues to meet the level of care eligibility for the TA waiver. The assessment is conducted and necessary information is obtained by the RN or ARNP contracted independent assessor who has been trained to conduct LOC eligibility determination. LOC reevaluation are conducted every 6 months, the following LOC needs are assessed:

1) Participant continues to meet the TA waiver definition for LOC eligibility
2) Participant continues to be dependent upon the medical technology
3) Participant requires the nursing acuity level provided by a nurse in the hospital

Following an assessment of the individual's medical technology and nursing acuity needs, the individual is deemed eligible if the participants meet the TA waiver definition and any of the following criteria:

Age 0-21 years with a minimum technology score of (50) points, or
Age 0 through 5 years with a minimum technology score of (25) points and a nursing acuity score of (20) points, or
Age 6 through 21 years with a minimum technology score of (25) points and an acuity score of (30) points.

4) Participant is determined Medicaid eligible
5) The assessment is reviewed and approved by the physician

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):*

The MATLOC database is complete and includes reporting features that enables Kansas to generate a listing of participants due for LOC eligbility reevaluations.

Re-evaluation due dates are generated upon submission of the completed assessment. A due date list will be generated into a workload that can be managed by the assessor.

The process for LOC eligibility re-determination occurs every six months and no earlier than 45 days prior to the reassessment due date.

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 are maintained in the participants case file by the contracted independent assessors/agencies who is responsible for performing the initial and reevaluation for a minimum period of 3 years or submitted to Kansas owned MATLOC database.

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: "Kansas Assessment Management Information (KAMIS) System or its related web application(MATLOC)".

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 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 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 = 95%
☒ **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**	☒ **Annually**

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

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

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):
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%
☒ **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:

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:
Matloc Records (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 assessors	☒ **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:

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

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 will be included as part of the comprehensive KanCare State Quality Improvement Strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of the contracted indepent assessors 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 a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through the KanCare QIS, 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.

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: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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.

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).

Freedom of choice is offered by the independent assessors during the initial and reassessment of LOC eligibility determination. THE MATLOC assessors use the RSP (Recommended Service Plan) document to indicate choice between HCBS and Institutional level of care. MATLOC Assessors use the Technology-Assisted Waiver Parental Checklist to indicate they've reviewed Rights and Responsibilities, Appeal and Grievance Rights and acknowledge they've been offered all waiver services.
Similarly, the KanCare MCO selected by the participant is responsible for providing or explaining the freedom of choice and "Participant Rights and Responsibilities" to the participant, parent or legal guardian. As part of the Person Centered Service Plan meeting the MCO Care Coordinator will review and gain signature from member or guardian the participant choice form and the Rights and Responsibilities 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.

Written copies or an electronically retrievable form documenting Freedom of Choice are maintained by the independent assessors and the KanCare MCO of participant's choice.

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. In order 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 consumers, states are required to capture language preference information. This information is captured in the demographic section of the MATLOC instrument.

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 consumers 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).

Translation of all Medicaid documents are provided on request. The KanCare managed care organization contracts require that they demonstrate cultural competency and for organizations to provide information in several languages. Here are examples of their links:
https://www.sunflowerhealthplan.com/language-assistance.html
https://www.sunflowerhealthplan.com/members/medicaid/benefits-services/diversity-translation.html
https://www.sunflowerhealthplan.com/members/medicaid/resources/interpreter-services.html
https://www.myamerigroup.com/KS/Pages/welcome.aspx
https://www.myamerigroup.com/KS/pages/contact-us.aspx
https://www.uhccommunityplan.com/MemberLanding/EN/MMemWell/WA/PlOver.html
https://www.uhccommunityplan.com/ks/medicaid/community-plan/member-information.html
https://www.uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/KS-MemberHandbook.pdf
State links:
http://www.kancare.ks.gov/docs/default-source/Consumers/apply/families-and-children/kc2100s---asistencia-m%c3%a9dica-para-familieas-con-ninos.pdf?sfvrsn=2
2003 E&D Policy Memos
Policy # Policy Name PM2003-10-02 Implementation Memo on Language/Other Media Preference and Race/Ethnicity Data Collection PM2003-10-01 Medical Assistance Changes Associated with Implementation of the new iCMMIS SOC2003-10 KEESM Revision 16 (10/1/03) Summary of Changes (SOC) - Implementation Memo (Additional Medical Changes) PM2003-08-01 Spenddown and Long Term Care (LTC) Changes SOC2003-07 KEESM

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	**Medical Respite Care**		
Statutory Service	**Personal Care Services**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Health Maintenance Monitoring**		
Other Service	**Home Modification**		
Other Service	**Intermittent Intensive Medical Care**		
Other Service	**Specialized Medical Care**		

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:

Respite

Alternate Service Title (if any):

Medical Respite Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Medical Respite Care is a temporary service provided on an intermittent basis for the purpose of relieving the family of the care of a technology dependent and medically fragile person for short, specified periods of time.

Respite care must be provided in the recipients place of residence or community and has its purpose:

The meeting of nonemergency or emergency family needs; restoration or maintenance of the physical and mental well-being of the child and/or family providing supervision, companionship and personal care to the child for the specified period of time.

Providers of medical respite service is limited to a skilled nursing staff (RN or LPN) licensed to practice in Kansas under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment.

Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

The limit is based on the provision of temporary, respite care, and can be delivered in addition to benefits available through the EPSDT state plan. If the person’s need were to exceed the medical respite limit, Specialized Medical Care can be utilized as an alternative and may be provided up to a maximum of an average of 12 hours per day or 372 hours (1488 units) per month.

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

A maximum of 7 days or 168 hours per calendar year will be provided.

The limit is based on the provision of temporary, respite care, and can be delivered in addition to benefits available through the EPSDT state plan. If the person's need were to exceed the medical respite limit, Specialized Medical Care can be utilized as an alternative and may be provided up to a maximum of an average of 12 hours per day or 372 hours (1488 units) 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	Specialized Medical Care- Respite Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Medical Respite Care

Provider Category:

Agency

Provider Type:

Specialized Medical Care- Respite Care

Provider Qualifications

License *(specify):*

Licensed in the State of Kansas to practice in the capacity of a nurse and is under the employment of a Home Health Agency. The provider of respite care must be licensed in the following:

- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)

Providers of Medical Respite Care service must meet licensing standard as defined by K.S.A 65-1115.

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:
-professional license / certification if required;
-adherence to KDADS training and professional development requirements;
-All staff must be in compliance with the KDADS' Background Check Policy;
-Must meet the licensing standards as regulated by Kansas State Board of Nursing in K.S.A 65-1115 and the Kansas Department of Health and Environment home health licensing requirement as specified in K.S.A 65-5101 through K.S.A. 65-5117 as applicable
-Must be employed under an enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver."

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent, and the KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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. PCS shall only be authorized for the time spent providing housekeeping to the participant's area of the residence.
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.

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

The services under the Technology Assisted Waiver are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.
PCS is not a default level of care for technology dependent and medically fragile children served on this program. This service should only be accessed when the participant is medically stable and the level of care needs can be fully met by the PCS; or PCS is elected at the option of the participant or participant's minor parent/legal guardian/ legally responsible person. An accommodation is allowable when the participant's only alternative is PCS service, the care coordinator is responsible for assessing the level of need to determine if the participant's medical needs can be fully met under PCS services. The care coordinator must take into consideration the assurance of the participant's health and welfare needs prior to authorizing PCS service.
PCS needs will be determined using the MATLOC instrument and Risk assessment, PCS may be provided up to 12 hours per 24-hour day. Exceptions to exceed the service limits as determined by the MATLOC and Risk assessment instrument is subject to the approval of KanCare MCOs.
Personal Care Services are limited to the assessed level of service need, as specified in the Person-Centered Service Plan, up to 12 hours per 24-hour day. The need to exceed the maximum service limit is subject to approval by the participant's MCO.
The MCO may authorize services exceeding the 12 hours per 24-hour day accommodation 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 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."
All Personal Services will be arranged for, reviewed, and approved by the KanCare MCO's Care Coordinator with the participant's written authorization, & paid for through an enrolled home health agency, when services are agency-directed, or an enrolled Financial Management Service (FMS) provider, when services are participant-directed. Payment for services must be made within the minimum approved reimbursement established by the state. A person may have several personal assistants providing him/her care on a variety of days at a variety of times, but a person may not have more than one assistant providing care at any given time, unless the one-on-one care is necessary to meet the health and welfare needs of the participant. Person-Centered Service Plans for which it is determined that the provision of Personal 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. Children receiving care in licensed foster care settings do not have the option to self-direct services unless established exception criteria are met. Unless otherwise approved by KDADS, all services must be provided through the agency directed service model.

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 Services (self-directed)
Agency	Personal Care Services (agency-directed)

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 Services (self-directed)

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. Be at least eighteen years of age; or
2. Must have a High School Diploma or equivalent;
3. Have the necessary training or skills in order to meet the needs of the participant.
4. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS)provider,acting as an administrative agent on behalf of the participant.
5. Medicaid enrolled provider, contracted and credentialed with KanCare MCO

All staff must be in compliance with the KDADS' Background Check Policy. Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications
Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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:

Personal Care Services (agency-directed)

Provider Qualifications
License *(specify):*

Licensed Home Health Agency

Certificate *(specify):*

Certified Home Health Aide in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.

Other Standard *(specify):*

a) Must have a high school diploma or equivalent;
b) Must be at least eighteen years of age or older;
c) Must meet the agency's qualifications;
d) Must reside outside of waiver recipient's home;
e) 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 to provide HCBSTA waiver services.
f) Must meet KDADS approved skill training requirements
All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS training and professional development requirements; All staff must be in compliance with the KDADS' Background Check Policy. All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS training and professional development requirements;

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent, and the KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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:

Financial Management Services

Alternate Service Title (if any):

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:

Access to this service is limited to individuals or individuals representatives who direct some or all of their services; or to individuals or individuals representatives who are planning to direct some or all of their services.
Kansas is promoting true choice by making options available to the participant or responsible party by entering in to an employment support with the Financial Management Services (FMS) provider and to work collaboratively with the FMS to ensure the receipt of quality, needed support services from direct support workers. The participant retains the primary responsibility as the common law employer. FMS service will be provided through a third-party entity.
The MCO will ensure that persons seeking or receiving participant-directed services have been informed of the benefits and responsibilities of the participant-direction and provide the choice of FMS providers. The choice will be presented to the person initially at the time participant-direction is chosen and annually during his/her Person-Centered Service Plan planning process, or at any time requested by the participant or the person directing services on behalf of the participant.
The MCO is responsible for documenting the provider choice. In addition, The MCO will be responsible for informing the participant of the process for changing or discontinuing an FMS provider and the process for ending participant-direction. The MCO will be responsible for informing the participant that agency-directed services can be made at any time if the participant no longer desires to participant-direct his/her service(s).
The FMS provider will provide information regarding participant direction relating to employer responsibilities, including potential liabilities associated with participant direction. Participant-direction (K-PASS participantdirection
tool kit) is available to all participants through the KDADS website. The participant and participant's representative are responsible for working collaboratively with their FMS provider to meet shared objectives.
"These objectives may include:
• Participant is receiving high quality services.
• Participant receives needed services from qualified workers.
• Tasks are provided in accordance with state law governing participant-direction, Medicaid and the State of Kansas requirements, and the Person-Centered Service Plan is authorized by MCO."
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 participant-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 participant-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 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."
"Information and Assistance Responsibilities
1. Explanation of all aspects of participant-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, managing workers, and providing effective communication and problem-solving."
"Where the possibility of duplicate provision of services exists, the participant Person-Centered Service Plan shall clearly delineate responsibilities for the performance of activities.
In addition to the MCO’s responsibility above, the FMS provider is also responsible for informing participant that he/she must exercise responsibility for making the choice to participant-direct his/her attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that was made. The FMS 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 information and assistance provided, at a minimum must include the following:"
"• Act as the employer for Direct Support Workers (DSW), or designate a representative to manage or help manage Direct Support Workers. See definition of representative above.• Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and
responsibilities of the participant and the FMS provider
• Establish the wage of the DSW(s)
• Select Direct Support Worker(s)
• Refer DSW to the FMS provider for completion of required human resources and payroll documentation. In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
• Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including work schedule.
• Provide or arrange for appropriate orientation and training of DSW(s).
• Determine schedules of DSW(s)."
"• Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the approved and authorized POC or others as identified and/or are appropriate.
• Manage and supervise the day-to-day HCBS activities of DSW(s).
• Verify time worked by DSW(s) was delivered according to the POC; and approve and validate time worked electronically or by exception paper timesheets.
• Assure utilization of EVV system to record DSW time worked and all other required documents to the FMS provider for processing and payment in accordance with established FMS, State, and Federal requirements. The EVV/timesheet will be reflective of actual hours worked in accordance with an approved POC.
• Process for reporting work-related injuries incurred by DSW(s) to the FMS provider."
"• Develop an emergency worker back-up plan in case a substitute DSW is ever needed on short notice or as a back-up (short-term replacement worker).
• Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
• Inform the FMS provider of any changes in the status of DSW(s), such as changes of address or telephone number, in a timely fashion.
• Inform the FMS provider of the dismissal of a DSW within 3 working days.
• Inform the FMS provider of any changes in the status of the participant or participant's representative, such as the participant's address, telephone number or hospitalizations within 3 working days.
• Participate in required quality assurance visits with MCOs, and State Quality Assurance Staff, or other Federal and State authorized reviewers/auditors."
"Payment for FMS
FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate."
The extent of the assistance furnished to the individual or individual's representative is specified in the service plan. This service does not duplicate other waiver services. Where the possibility of duplicate provision of services exists, the individual's service plan shall clearly delineate responsibilities for the performance of activities.

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

Financial Management Service (FMS) 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 chose an FMS provider of his/her preference and 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 Kansas 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 Kansas Medicaid Provider of Financial Management Services

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Enrolled FMS providers will furnish Financial Management Services according to Kansas model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.
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. The agreement will be renewed annually and approval is subject to satisfactory completion of required financial audit. 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.
o Including process for conducting background checks
o Process for establishing and tracking workers wage with the participant"
"The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied as part of a readiness review 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.
All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; all staff must be in compliance with the KDADS' Background Check Policy. Any provider or provider assistant found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.
Prospective providers are not permitted to provide services to a participant until verification of background clearance is available for review by the participant in accordance with the list of prohibited offenses (KSA 39-3970 & 65-5117).

Verification of Provider Qualifications

Entity Responsible for Verification:

KDHE, KDADS and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of the provider qualifications. The oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

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:

Health Maintenance Monitoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service is provided in conjunction with agency-directed or self-directed attendant care service to provide ongoing evaluation and oversight of the participants health and welfare status. This service is intended to assure the participants medical needs are being met when his/her healthcare is being managed by a non-licensed agency or self-directed attendant. Specifically, the service to be provided includes the following:

1) General healthcare assessment
2) Assess vital signs
3) Assessing for proper healthcare management activities
4) Assessing for appropriate medication administration
5) Consultation with the participant/ parent/ legal guardian regarding assessment and participant's general healthcare status
6) Report assessment findings to MCO Care Coordinator
7) May include delegation or supervision of KDAD'S approved health maintenance activities

The participant may select his/her provider of choice.

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

This service is limited to participants who have chosen to have their healthcare needs managed by an agency-directed or self-directed non-licensed attendant.
Service is limited to one unit per quarter (every three months). One unit is equal to one visit. At the time of waiver development this was assessed as promoting formalized oversight for non-licensed providers with a knowledge that individuals would also be receiving a professional level of service in most cases.
This service cannot be provided in conjunction with or overlap with Intermittent Medical Care , Specialized Medical Care , or Medical Respite .
This service cannot be provided by legally responsible persons, relatives, or legal guardians.

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	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Maintenance Monitoring

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

-Licensed Practical Nurse or
-Registered Nurse
-Must hold a current license issued by the Kansas State of board of nursing in accordance with K.S.A 65-1113

Certificate *(specify):*

Other Standard *(specify):*

Must have a minimum of 2 years nursing experience in working with individuals
with special health care needs
Must be employed by and under the direct supervision of a private or public home health agency licensed by the Kansas Department of Health and Environment."
"All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:
-professional license / certification if required;
-adherence to KDADS training and professional development requirements;
-All staff must be in compliance with the KDADS' Background Check Policy.
-Must meet the licensing standards as regulated by Kansas Department of Health and Environment as specified in K.S.A 65-5101 through K.S.A. 65-5117
-Must be employed under and enrolled Medicaid provider authorized to provide services under the HCBS-TA Waiver

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment, (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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 Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

For the purpose of this waiver, home modification services are defined as modifications to the participant's home. The need for home modification is an identified necessity to assist individuals in the day to day function as indicated in the Person-Centered Service Plan. The goal is to assist participants in supporting their independence, mobility and maintain their productiveness in the community.

The reimbursement of home modification services are limited to:

a. Purchase a participant transfer lift
b. Purchase of or installation of ramp not covered by any other resources;
c. The widening of doorways;
d. Modifications to bathroom facilities owned by the individual, parent or legally responsible party where participants reside;
e. Modifications related to the approved installation of modified ramps, doorways or bathroom facilities
f. Services shall be provided within specified local and state building codes.
g. Modifications are made within the existing structures and must not result in addition of square footage to the existing structure.

Home Modification Services limits are set based on historical case information of other waiver services and reimbursement data demonstrates the adequacy of the limit in addressing individuals needs.

Home modification needs will be assessed and approved by the KanCare MCO, the MCO may determine the need for home modification from the Medical Assistive Technology Level of Care (MATLOC) instrument. To avoid any overlap of services, Home Modification Services are limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System). HCBS-TA waiver funding is used as the funding source of last resort.
The services under the Technology Assistance Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Exclusion: excluded from these adaptations or improvements to the home that are of a general utility and are not of direct medical or remedial benefit to the participant.

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

This service is limited up to a lifetime maximum of $7500.00 for the participant of the TA waiver program.Each unit of service may cost up to $ 7500.00, multiple units of billing is allowed for this service up to the maximum lifetime limit. The services under the Technology Assistance Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Home Modification Provider
Individual	Home Modification Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Agency

Provider Type:

Home Modification Provider

Provider Qualifications

License *(specify):*

- General Contractor
- DME provider

Certificate *(specify):*

General contractors must provide proof of certificate of Worker's Compensation and General Liability Insurance

Other Standard *(specify):*

All non-licensed general contractor must present a current certification of worker's compensation and general liability insurance, including proof of business establishment at a minimum of 2 consecutive years.
A Medicaid enrolled General contractor eligible to provide services as specified in this section of appendix ""C"" under service specification. The property must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides."
"All general contractor service providers, if required must meet the local city and state building codes. DME service providers must distribute product and services in accordance with K.A.R 30-5-58.
For this specific service, durable medical equipment (DME) providers must meet statutory requirement to provide DME services. A general contractor whose service is to construct or modify a dwelling for the purpose of providing home modification services must adhere to the local and county code requirements for the city/ county location the service was provided."
Providers of this service must meet all standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; all staff must be in compliance with the KDADS' Background Check Policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment, (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modification

Provider Category:

Individual

Provider Type:

Home Modification Provider

Provider Qualifications

License *(specify):*

General contractor

Certificate *(specify):*

Certificate of Worker's Compensation and General Liability Insurance

Other Standard *(specify):*

All non-licensed general contractor must present a current certification of worker's compensation and general liability insurance, including proof of business establishment at a minimum of 2 consecutive years.
A Medicaid enrolled General contractor eligible to provide services as specified in this section of Appendix C under service specification. The property must be occupied and owned by the participants or the parent or legally responsible individual where the participant resides.
All service providers, if required must meet the local city and state building codes.
Providers of this service must meet all standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; all staff must be in compliance with the KDADS' Background Check Policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment, (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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:

Intermittent Intensive Medical Care

HCBS Taxonomy:

Category 1: 05 Nursing

Sub-Category 1: 05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

The service provide specialized nursing skill targeted for this technology dependent and medically fragile population; the services provided under EPSDT do not meet the chronic, long-term needs of this target population with complex medical issues. Participants who are eligible to receive EPSDT services may access those services through the Medicaid state plan.
This service is provided by a Registered Nurse (RN) level only. IIMC is designed to meet the participant's intermittent skilled nursing needs when he/she has chosen to meet his/her routine health maintenance care needs with an attendant level of care. It is designed to provide the participant with additional service choice in order to meet specific skilled nursing care needs that cannot be performed by an attendant. This service is intermittent and must be identified as medically necessary service in the level of care assessment instrument. These specific nursing care elements are identified in the hydration/ specialty care section of the MATLOC assessment. These elements include but not limited to the following:

IV therapy administered less than every 4 hours daily
IV therapy intermittent to be delivered less than 4hrs per day weekly or monthly
TPN central line delivered less than 4 hours daily
Blood product admin less than 4 hours, intermittently weekly or monthly
IV pain control less than 4 hours daily
Lab draw each peripheral
Lab draw each central
Chemotherapy IV or injection
Home dialysis administration

Services provided under Intermittent Intensive Medical Care (IIMC) must be authorized and managed by a licensed healthcare provider (Physician, PA, ARNP), is medically appropriate and necessary for managing the healthcare needs of the participant. This service will be coordinated and monitored by the KanCare MCO care manager.

IIMC service may be provided in all customary and usual community locations including where the individual reside and socializes.

IIMC service does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.

The service may not be provided in conjunction with or overlap with Health Maintenance Monitoring, Medical Respite or Specialized Medical Care services.

The service may be provided in conjunction with agency or self directed attendant care services.

Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the Person-Centered Service Plan.

The medical necessity of this service is subject to the nursing acuity assessment as identified in the Medical Assistive Technology Level of Care (MATLOC) instrument and the participant's Person-Centered Service Plan.

IIMC service requires prior authorization and will be provided by the KanCare MCO.

The participant may select his/her provider of choice to deliver the needed care.

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

This service is not designed for medical needs identified as requiring more than 4 hours of nursing intervention. During the assessed level of care need, the MCO Care Coordinator will determine and coordinate the most appropriate service to meet the medical needs of the participant.

IIMC service may not be provided in conjunction with Specialized Medical Care service. The services under the Technology Assistance Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
Intermittent Intensive Medical Care Service is non-duplicative of services provided under EPSDT. At the time of development of the waiver, the historical information received from the ACIL program helped define not only the service but the time needed to deliver this service on an intermittent intensive level. Typically this service is used following hospital discharge or change in the child's health at home.

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	Licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Intensive Medical Care

Provider Category:
Agency
Provider Type:

Licensed Home Health Agency

Provider Qualifications

License *(specify):*

-Licensed Registered Nurse (RN)
-Hold a current license granted by the Kansas State Board of Nursing (KSBN)to practice in the capacity of a registered nurse in accordance with K.S.A 65-1113.

Certificate *(specify):*

Other Standard *(specify):*

Other standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:
" professional license / certification if required;
- adherence to the State training and professional development requirements;
- All staff must be in compliance with the KDADS' Background Check Policy.
- meeting the licensing standards as regulated by Kansas Department of Health and Environment as specified in K.S.A 65-5101 through K.S.A. 65-5117;
- employment under an enrolled Medicaid provider authorized to provide services under the HCBS TA Waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment, (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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:

Specialized Medical Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

In 2008, under CMS advisement, the state of Kansas, amended the TA waiver to include skilled nursing services previously provided under the state plan ACIL, Attendant Care for Independent Living service.
This service provides, the specific population of technology assisted and medically fragile children.
This service provides long-term home and community nursing support for medically fragile and technology dependent waiver recipients. The required nursing level of care is intended to provide medical support for individuals requiring ongoing daily hospital level of care in the participant's place of residence or community in lieu of hospitalization. The service is to effectively address the intensive medical needs of the participant and prevent hospitalization or the need for long-term hospitalization so that participant may choose to live in the community.
"For the purpose of this waiver, providers of Specialized Nursing Care services are typically provided by a Registered Nurse (RN), or Licensed Practical Nurse (LPN)under the supervision of a Registered Nurse, trained to deliver skilled nursing services identified in the Person-Centered Service Plan which are within the scope of the State's Nurse
Practice Act. Providers of this service are trained with the medical skills necessary to care for and meet the medical needs of individuals served under the TA Waiver. The level of service needs will be determined based on the MATLOC acuity/ risk assessment instrument.
Services cannot be provided to more than two (2) TA participants related or unrelated living in the same home. One nurse may provide Specialized Medical Care to two TA participants, related or unrelated and living in the same home, as long as both participants are served by the same MCO.
If more than one TA recipient reside in the same home and the level of care needs cannot be met by a personal care attendant, the MCO must meet the level of need with appropriate staffing."
"The service may be provided in all customary and usual community locations including where the individual resides and socializes.
It is the responsibility of the provider agency to ensure appropriate levels of nursing is employed and utilized to meet the specific medical needs of the participant.
Specialized Nursing Care service does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost
Participants who are eligible to receive EPSDT services may access those services through the Medicaid state plan. Specialized Medical Care targeted for this population are non-duplicative of services provided under EPSDT.
The services under the Technology Assistance Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Parent/ Legal Guardian who provide specialized medical care services under professional services under defined condition is limited to 8 hours per day, not exceed 40 hours per week. Persons delivering services under the provision of "extraordinary care" are providing Specialized Medical Care service under the direction of a Physician and are an employee of a Home Health Agency, enrolled as a Medicaid provider of HCBS-TA Waiver services
The services under the Technology Assistance Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Specialized medical care services are limited to a maximum of an average of 12 hours per day or 372 hours (1488 units) per month. One unit is equal to 15 minutes.

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	Specialized Medical Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Care

Provider Category:
Agency
Provider Type:

Specialized Medical Care

Provider Qualifications

License *(specify):*

Registered Nurse (RN)
Licensed Practical Nurse (LPN)

Certificate *(specify):*

- Hold a current license granted by the Kansas State Board of Nursing (KSBN)to practice in the capacity of a nurse in the Kansas.

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific professional field through which service is provided including but not limited to:
-professional license / certification if required;
-adherence to KDADS training and professional development requirements;
-All staff must be in compliance with the KDADS' Background Check Policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment, (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE

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):

The contractor / sub contactor and /or provider agency must be in compliance with the KDADS' Background Check Policy for the following waiver services:
- Fiscal Management Service
- Health Maintenance Monitoring
- Intermittent Intensive Medical Care
- PCS
- Medical Respite
- Specialized Medical Care"

Effective March 6, 2017, per K.S.A. 39-2009 (i) “the licensee operating a center, facility, hospital or a provider of services shall request from the Kansas Department for Aging and Disability Services information regarding any criminal history information relating to a person who works in the center, facility, hospital or for a provider of services, or who is being considered for employment or volunteer work in the facility, center, hospital or with the service provider, for the purpose of determining whether such person is subject to the provisions of this section”. To be a qualified Home and Community Based Services (HCBS) provider of services that involve or may involve one-on-one contact with the HCBS service recipient, individuals and entities must meet the provider qualifications, which include passing a background check. The requirements have been standardized to ensure consistency, efficiency, and effectiveness for background checks of individuals and entities providing long-term services and supports to individuals participating in the HCBS programs. The HCBS programs include waiver programs as well as the Work Opportunities Reward Kansans (WORK) program. Criminal background checks must be submitted through the Kansas Department for Aging and Disability Services (KDADS) Health Occupations Credentialing, the Kansas Bureau of Investigation, or any other entity with access to criminal history information, including adjudications of a juvenile offender which if committed by an adult would have been a felony which is a crime against persons (K.S.A. 39-2009 (2)).The background check policy is statewide.

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):

The State maintains an abuse registry and requires the screening of individuals through this registry.
The contractor / sub contactor and /or provider agency must complete a background check on the performing employee against the Kansas Department for Children and Family (DCF) child and adult abuse registries. DCF maintains the registries for all confirmed perpetrators. Providers of services identified below must undergo an abuse registry screening in addition to maintaining a clear background check as specified in the provider qualifications.
" Fiscal Management Service
- Health Maintenance Monitoring
- Intermittent Intensive Medical Care
- PCS
- Medical Respite
- Specialized Medical Care
The contractor / sub contactor and /or provider agency must upon request by KDADS provide evidence that required standards have been met or maintained at the renewal of their professional license. This standard can be reviewed by KDADS Regional Field Staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a license or certification, if applicable may be formally reviewed by KDADS to determine whether the licensee continues to be in compliance with the waiver service requirements. Any provider or provider assistant found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding

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).**

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.*

Waiver services are not intended to provide care and supervision of minor children. Parents and legal guardians may provide services to minor children if mitigated by the courts and have a designated representative. PCS is for those services above regular care and supervision.

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. See HCBS Conflict of Interest 06/15/2015 and Personal Care Services and Limitations Policy effective 02/01/2016.
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 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 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:

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

c) The participant has exhausted other support options offered by the MCO and absent PCS 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 services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

KDADS allows legally responsible individuals to provide Specialized Medical Care under the following circumstances: A parent may be reimbursed when providing Specialized Medical Care services for the waiver participant. The parent of a minor child may be paid under the Medicaid program if the parent of a minor child lives with the waiver-eligible consumer or child, and has been determined to be a person essential to the participants well-being in accordance with K.A.R. 30-5-307. The parent of the minor child must also have received the training and licensing necessary to perform the nursing level that is deemed extraordinary above normal parental duties.
Limitation of services is governed by the assessed need of the consumer based on the nursing acuity and the individual/family needs assessments. The number of service hours is limited to the assessed medical need and parent's ability to safely care for the participant in the capacity of a paid caregiver and his/her responsibility as a parent. Services greater than the assessed need of the consumer or established limits are not furnished by the waiver.
Services that may be furnished by a relative or legal guardian are limited to the scope, duration and amount determined by the MCO needs assessment and authorized in the participants' Person-Centered Service Plan.

When the above criteria for responsible individuals to provide services is met with conflict of interest mitigated, Kansas believes that this arrangement is in the best interest of the recipient.

○ **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:

In order to comply with CMS Managed Care Rule 2390,effective January 1, 2018, All providers must enroll and obtain a Kansas Medical Assistance Program (KMAP) identification (ID) number prior to contracting with a KanCare managed care organization (MCO). This requirement applies to new providers and existing KanCare providers at the time of re-credentialing. Providers will be unable to re-credential or initiate a new network provider agreement with a KanCare MCO until a KMAP ID number is received.
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.

KDADS, in collaboration with KDHE, completed a systemic assessment against 42 CFR § 438.207. Modifications to MCO reporting for network adequacy have been developed. Network adequacy is reported quarterly through the KanCare Administrative Report System. KDADS program operations staff have access to these reports and participate in ongoing monitoring activities.

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%
☒ **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 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%
☒ **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 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 enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements N=Number of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of all enrolled 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%
☒ **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 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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%
☒ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group:

KanCare Managed Care Organizations (MCOs)		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:

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 a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through the KanCare QI Strategy, 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 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 KanCare QI Strategy.

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 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.

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.

Please see Attachment #2 for the HCBS-TA and Statewide Transition Plan.

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):*

- [x] **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:
- [x] **Other**
  Specify the individuals and their qualifications:

Kansas has contracted with managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for Person-Centered Service Plan development, and will be using their internal staff to provide that service. Kansas requires that conflict of interest be mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers the Person-Centered Service Plan development, and making that an MCO function.(In addition, conflict has been mitigated by Kansas separating the level of care determination from any service delivery or Person-Centered Service Plan development.) Some of the additional safeguards that will be in place to ensure that there is no conflict of interest in this function include the operational strategies for each MCO that
are described in detail at Section D.1.d of this appendix. TA Waiver Care Coordinators are state licensed R.N.'s.

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.

When the contracted independent assessor has determined an individual likely to require the level of care provided in a hospital, the participant/parent/legal guardian or legal representative will be given a choice of MCO. The participant's chosen KanCare MCO provides certain information and support to the participant regarding available services and the plan development process. The MCO: (1) provides information to the participant and/or his/her legal representative regarding alternate service options available through the TA waiver, and (2) offers the choice of either institutional care or home and community based services (HCBS). The participant indicates on the Participant Choice form, his/her choice of institutional care or HCBS. Through the use of this document, and a list of rights and responsibilities, the participant is counseled regarding his/her participation in the service plan design and informed of the self-direct option.

The participant's authority is established through service provider training which stresses both civil rights of individuals with disabilities and independent living philosophy. This approach is reinforced through regulation (K.A.R. 30-5-309) which requires the individual participation in, and approval of, the plan. The participant's authority is further reinforced by program policies and procedures which indicate the participant's choice in plan development process.

This program primarily serves children, the parent/legal guardian is typically the individual responsible for decision making and engaging in the service development planning process. However, the participant has, unless a guardian is in place, the right to determine who is included in the process to determine which service is needed, which service providers to use, and which FMS agency to use for self-directed services.

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):

a)When an applicant is determined eligible for services and chooses to receive services, the MCO care coordination entity
of choice will educate the participant/parent/legal guardian or legal representative regarding the Person-Centered Service Plan process and the services available to the participant. In order to coordinate services, the MCO care coordination entity will refer to the " Person-Centered Service Plan" form in which the participant/parent/legal guardian or if an adult, a legal representative of his/her choice participates in the selection waiver services and its provider(s) of choice.
Unless a different timeframe is requested by the participant applying for services, or their legal representative, if appropriate, within five (5) working days of the referral, the contracted independent assessor conducts the level of care assessment of the participant applying for waiver services. The Person-Centered Service Plan is developed during a face-to-face meeting with the participant, guardian (if applicable), the MCO, and any selected representatives that the participant chooses to be involved. With the participant's approval, family members and other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development and implementation of the Person-Centered Service Plan. The location of the Person-Centered Service Plan meeting is normally in the participant's home but arrangements can be made for another location if the participant desires.

b) The Care Coordinator will refer to the MATLOC instrument in addition to their organization's needs assessment tool for a comprehensive evaluation of the participant care needs in order to develop a Person-Centered Service Plan.
"The assessment of service needs should include the following components:
• Medical assisted technology needs;
• Attendant and skill nursing level of care needs;
• Comprehensive evaluation of the participant's health;
• Communication and social needs;
• Home and environment support needs;
• Availability of Informal and formal supports;
• General health needs, goals and personal preferences;
• Environmental, familial and social risk factors.
All these considerations and input from the participant/parent/legal guardian or legal representative assist the KanCare MCO entity in developing and coordinating the services appropriate to meet the participant's needs. All informal supports and non-waiver services are considered in order to assure non-duplication of waiver services."
The participant/parent/legal guardian or legal representative is the primary source of information. The KanCare MCO entity may contact other sources such as physicians, other health care providers, or family members to obtain necessary information for the purpose of developing a Person-Centered Service Plan. A request for release of information must be granted and signed by the participant or designee for representatives who have no legal authority or DPOA for the participant.
"It is the responsibility of the KanCare MCO entity to coordinate waiver and non-waiver services in order to address the needs of the participant.
The KanCare MCO entity will review the rights and responsibilities of being a HCBS-TA waiver participant/parent/legal guardian or legal representative, and discuss responsibilities in monitoring services. The participant/parent/legal guardian or legal representative will need to plan with the KanCare MCO entity a follow up schedule to better evaluate participant's needs, the participant shall choose the time and frequency of the follow up visits, and this must be included in the participant's Person-Centered Service Plan."
KanCare MCO services are ongoing and provided in the participant's place of residence or community. The reassessments are to be conducted at least every six months and more frequent if necessary. The participant/parent/legal guardian or legal representative is responsible for reporting any changes in services, or changes in the quality of services, provided. Dependent upon the frequency of the care coordinator's visits, the care coordinator is responsible for monitoring of service implementation and services provision, including the quality of services at a minimum of every six months and ongoing as necessary.
c) Participants are informed of services available through the waiver program by the contracted assessor during the initial assessment and eligibility determination process. This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the participant's needs.
d) The plan development process ensures that the service plan addresses the participant's needs, goals, and preferences as assessed by the MATLOC instrument and MCO needs assessment.

e) Person-centeredness of the plan is reinforced
through regulation which requires participation in, and approval of, the plan (K.A.R. 30-5-309).
The participant has the right to make changes at any time.

f)The plan development process is further ensured
by the direct involvement of, and monitoring by, the participant and/or legal representative, and any persons identified by the participant to be involved in the plan development process.

g)Changes to the plan can be made at any
time to reflect changes in the participant's needs, with reassessment conducted at least every six months. Upon authorization of the plan, and when changes in status occur, the MCO is required to notify the participant, the legal representative, if appropriate, all service providers, and the participant's FMS provider of the authorization by use of a Notice of Action (NOA) form and participant's PCSP. Thus, all involved parties are informed and serve to monitor and advocate for the needs and wishes of the participant. If at any time, an action is taken related to the service plan that does not meet the satisfaction of the participant; the participant may utilize the MCO's grievance process or the state fair hearing process that would ultimately ensure the participant's needs are being met.
Waiver and other services are coordinated by the MCO's care management staff who utilizes knowledge of available services, both formal and informal in the participant's community, as well as information from the participant regarding his/her current utilization of those services as well as other available services including Medicaid health services. Currently utilized services and available community services are taken into consideration as the participant and the MCO design the Person-Centered Service Plan.

h)In the event, the Recommended Service Plan/Expedited Service Plan is used, this can occur when children need to be discharged from the hospital with services in place before they can be released. Children's Mercy often requires this in order to discharge the child. The Recommended Service Plan/Expedited Service Plan can have include waiver services. The Recommended Service Plan/Expedited Service Plan will be in place until the MCO Care Coordinator has their Person Centered Service Plan in place no later than fourteen working days from notification to the MCO of eligibility. The MCO Care Coordinator then follows the process described 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 takes into account information from the MATLOC assessment which identifies the following;
- Medical technology needs
- Nursing level of care needs
- Risk factors and health indicators
- Goals and objectives tailored to address the needs of the individual
- Availability of informal supports"

"The Person-Centered Service Plan will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service. The Person-Centered Service Plan is the fundamental tool by which the State will ensure the health and welfare of the participant receiving services under the TA waiver.

The Person-Centered Service Plan will be subject to periodic review and update. 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 and medical needs."

. It is the responsibility of the MCO care coordinator to work with the family to develop a backup plan in the event staff is unavailable. Evidence of a backup plan is required within the MCO person-centered service plan and is monitored by way of quarterly record reviews performed by KDADS quality management staff.

Each participant's Person-Centered Service Plan is reviewed for emergency contact information during the assessment, and each family and support team will need to have a backup plan with both formal and informal providers selected. Back up plans will need to support the health and welfare needs of the participant. Examples of back up plans could include evacuation planning, notification of utility companies regarding the urgency in power restoration or maintenance due to the life sustaining device and /or backup staff in the event scheduled staff would not be available to work. It is the responsibility of the MCO care coordinator to work with the family to develop a backup plan in the event staff is unavailable.

Strategies to minimize risk include assessment of risk factors by the level of care eligibility assessors every six months utilizing an extension of the MATLOC level of care instrument. In addition, the program requires the participant/ parent/legal guardian to sign their agreement acknowledging the risks and their responsibilities as a condition of program participation. This is documented on the "Parent Acknowledgement" form which is available to CMS upon request.

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.

Each participant found eligible for TA waiver services can choose to receive services through the waiver program. Participants are assisted with this choice by each participant's chosen KanCare MCO, who outlines services provided by the waiver. The participant's choice of service options is indicated on the Participant Choice form provided to the participant by the MCO. This same form is used by participants to indicate whether or not they choose to self-direct their attendant care services.

If the participant chooses to receive waiver services, the MCO provides a list of all the service access agencies, including Financial Management Services, to the participant and assists with accessing information and supports from the participant's preferred qualified provider. These service access agencies have and make available to the participant the names and contact information of qualified providers of the waiver services identified in the Person-Centered Service Plan.

The State assures that each participant found eligible for the waiver will be given free choice of all qualified providers of each service included in his/her written Person-Centered Service Plan. The MCO presents each eligible participant a list of providers from which the participant can choose for self-directed services and a list of service providers for agency-directed services. The MCO assists the participant with assessing 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 of the waiver services identified in the Person-Centered Service Plan.

Participants have available access to an updated list of TA waiver service provider agencies through the managed care organizations website. KDHE and KDADS will provide a link to the MCO website. The MCO is responsible for ensuring a provider list is made available to participants who do not have access to technology.

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):

The participant's chosen MCO and the participant develop the participant's Person-Centered Service Plan from information gathered in the assessment. Further monitoring of services is conducted by the state consistent with the comprehensive KanCare quality improvement strategy. Included in that strategy is review of data that addresses:
"• Access to services
• Freedom of choice
• Participants needs met
• Safeguards in place to assure the health and welfare of the participant are maintained
• Access to non-waiver services and informal supports
• Follow-up and remediation of identified programs"

For the TA waiver quality strategy, the following process is utilized and reported quarterly to the KDHE LTC.
A representative sample of HCBS Waiver individual's case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS' Financial and Information Services Commission (FISC), and assigned to the appropriate Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a "non-review" and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a "non-review."

Case specific documentation for Quality Reviews shall be completed by desk review or provider's on-site location. For desk reviews, file documentation should be uploaded in the systems of record, to
include but not limited to the Quality Review Tracker (QRT) by the MCO's and KAMIS by the Assessor's. QMS will review documentation by using the established protocols. For on-site reviews, file documentation uploaded by the MCO's and/or Assessor's, will be reviewed by QMS using the established protocols at the designated provider locations. Findings for desk and on-site reviews will be recorded in Quality Review Tracking system (QRT) for the MCO/Assessor's remediation.

Data analysis is completed and remediated for any assurance or sub-assurance less than 87%. KDADS staff will notify the provider of areas below 87% with details of each finding. The provider will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.
Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.
Findings or concerns on a specific case identified through the review by QMS will be entered in QRT. Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

KDADS estimates the statistical range of values within which the true target population is likely to fall, and how certain we can be that the true population value is within the range of values. The sample sizes prepared for the quality review team use a probability sample method, using a multi-stage, stratified sample.
• The sample size is determined by total waiver population, or with some measures, the total population of those waiver members with whom the measure is applicable (example, some measures are only applicable to new waiver eligibles only).
• In respect to the degree of accuracy, the random samples are prepared with a 95% confidence level that the confidence interval of each measure (the measure metric) meets the standard denoted in each measure, with a +/-5% margin of error.
• Finally, we oversample by 30%, to insure the output the quality review team submits for reporting meets the 95% confidence level requirements of each waiver population and measure.

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**
- [x] **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 KanCare contracting managed care organizations are responsible for monitoring the implementation of the Person-Centered Service Plan that was developed as a partnership between the consumer and the MCO and for ensuring the health and welfare of the consumer with input from the TA Program Manager, involvement of KDADS Regional Field Staff, and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).
"On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and consumer needs to ensure:
• Services are delivered according to the Person-Centered Service Plan;
• Consumers have access to the waiver services indicated on the Person-Centered Service Plan;
• Consumers have free choice of providers and whether or not to self-direct their services;
• Services meet consumer's needs;
• Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
• Consumer's health and safety are assured, to the extent possible; and
• Consumers have access to non-waiver services that include health services."
"The Person-Centered Service Plan is the fundamental tool by which the State will ensure the health and welfare of consumers served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated plans of care.
In-person monitoring by the MCOs is ongoing:
• Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the consumer.
• Choice is documented.
• The Person-Centered Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually."
In addition, the Person-Centered Service Plan and choice are monitored by state quality review and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the TA 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. That plan is contributed to and monitored through the KanCare QI Strategy, which includes HCBS waiver 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 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 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%
☒ **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%
☒ **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 results as determined by the State operating agency	
	☐ **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%
☒ **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 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%
☒ **Other** Specify: KanCare Managed Care Organizations	☐ **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 whoses 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%
☒ **Other** Specify: KanCare Managed Care Organizations	☐ **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 parrticipate 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 person-centered service plans reviewed within required timeframes as specified in the approved waiver N=Number and percent of person-centered service plans reviewed within required timeframes as specified in the approved waiver D=Number of waiver participants whose person-centered 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%
☒ **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 documented change in needs whose service plan was revised, as needed, to address the change N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants with a documented change in needs whose service plans require a revision.

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

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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 = 95%
☒ **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 results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 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:
Electronic Visit Verification (EVV) reports when applicable 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%
☒ **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):*

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 QMS 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%
☐ **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:

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%
☒ **Other** Specify: KanCare Managed Care Organizations	☐ **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 the 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 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 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%
☒ **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 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 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%
☒ **Other** Specify: KanCare Managed Care Organizations	☐ **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 the 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.

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 Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, 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. As the KanCare program is operationalized, staff of the three plans will be engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. Over time, the role of the MCOs in collecting and reporting data regarding the waiver performance measures will evolve, with increasing responsibility once the MCOs fully understand the Kansas programs. 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, 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 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.
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**
☒ **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 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.

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.

In this program, participant direction is offered under Personal Care Service (PCS). The participant is offered an opportunity during the initial and Person-Centered Service Plan reevaluation process to choose participant-direct (PCS) service. Following the assessment, if the participant is determined to be medically stable and determined appropriate to meet the medical needs of the participant safely, the participant, or legal representative has the optio to choose whether or not to participant-direct his/her (PCS) service. If participant-direction is chosen, the MCO will assist the participant or legal representative by reviewing the responsibilities of participant-direction and in addition to the following;
i. Assist the participant or legal representative in selecting a FMS provider serving in his/her area by providing a list of Medicaid enrolled FMS provider.
ii. Review with the waiver participant the liabilities and his/her rights and responsibilities when he/shechooses to participant-direct.
iii. Assist participant/legal representative in connecting with an FMS provider.
iv. Waiver participants who chose to direct his/her (PCS) service under the waiver are permitted to choose any qualified providers to deliver the service, subject to meeting the qualifications established by KDADS. v. The participant/legal representative is responsible for the following:
1. Complete an agreement with an enrolled Financial Management Services (FMS)provider;
2. Complete a work agreement with the direct service provider;
3. Review the Self-direction tool-kit;
4. Recruit and select the direct service worker and direct the individual to the FMS agent for enrollment and completion of employment documents;
5. Referral of direct service worker to the participant's chosen FMS provider;
6. Determine worker’s wage within specified Medicaid wage range minus applicable payroll deductions;
7. Provide appropriate training and authorization of delegated tasks as identified in the PCS Skill Checklist in order to appropriately meet the medical needs of the participant;
8. Assign work hours to the direct service worker(s) within the authorized limits specified in the plans of care;
9. Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
10. Other monitoring of the direct service worker’s work and dismissal of direct service worker, if necessary;
11. Arrange for a backup plan in the event a direct service worker does not report for work in order to maintain continuity of care, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned direct service worker.
All (PCS) services will be arranged for, purchased under the participant’s written authority, and paid for through the FMS agent. The FMS provider is responsible to providing employer support, specifically two distinct types of tasks: (1) administrative Tasks and (2) Information and Assistance (I & A) Tasks.
Alternatively, if participant-direction is not chosen, the MCO will provide the participant or legal representative a list of agency-directed services available to meet the participant’s needs. The MCO will be responsible for coordination of needed services identified as an assessed need for the participant. The MCO will facilitate and coordinate services with waiver service providers within the developed Person-Centered Service Plan.

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 parent/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 (PCS)only. Participant-direction is not offered for the following services:

- Health Maintenance Monitoring
- Home Modification
- Intermittent Intensive Medical Care
- Medical Respite Care
- Specialized Medical Care Services

Participant-direction is not an option when the participant/parent/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in a fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be referred by the MCO to KDADS for concurrence of action and is subject to the grievance and appeal protections detailed in Appendix F.

The state has added other criteria that could be used to define cases where participant-direction would not be a viable option. Namely, this includes a clinical determination based on the following criteria which are established in state policy at the time of this renewal.
For self-directing participants:
A participant who chooses to self-direct care is not required to have the PCS supervised by a nurse or physician to perform health maintenance activities if:
(1) Health maintenance activities can be provided without direct supervision ". . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the participant if the participant were physically capable, and the procedure may be safely performed in the home." K.S.A. 65-6201(d); and
(2) Health maintenance activities and medication administration and assistance are authorized, in writing, by a physician or licensed professional nurse.
b. The participant's failure to properly supervise or direct health maintenance activities delegated to the participant by a physician or licensed professional nurse could result in the termination of self-direction for those activities.

(3) Self-directing participants employing PCS workers who have a written physician's or registered nurse's statement to delegate health maintenance activities, including medication administration and assistance, is responsible to supervise PCS workers and train them to administrate medication according to the physician's order.

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.

Participants on this waiver or parent/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 (PCS) only. Participant-direction is not offered for the following services:

i. Health Maintenance Monitoring
ii. Home Modification
iii. Intermittent Intensive Medical Care
iv. Medical Respite Care
v. Specialized Medical Care Services
vi. Medical Service Technician

Participant-direction is not an option when the participant/parent/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in a fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be referred by the MCO to KDADS for concurrence of action and is subject to the grievance and appeal protections

Participants are informed that, when choosing participant direction, they must exercise responsibility for making choices about (PCS) service, 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 direct their services:
i. limitation to PCS;
ii. need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
iii. related participant responsibilities;
iv. potential liabilities related to the non-fulfillment of responsibilities in self-direction;
v. supports provided by the managed care organization (MCO) they have selected;
vi. the requirements of a PCS;
vii. the ability of the participant to choose not to participant direct services at any time; and
viii. other situations when the MCO may discontinue the participant's option to direct their services and recommend agency-directed services.

The MCO is responsible for sharing information with the participant about participant-direction of services by the participant. The FMS provider is responsible for sharing more detailed information about participant-direction once the participant has chosen this option and identified an enrolled provider. This information is also available from the TA Program Manager, KDADS Regional QMS, and is also available through the online version of the HCBS-TA Waiver Policies and Procedures Manual.

Information regarding participant-directed services is initially provided by the MCO during the plan of care/service plan development process, at which time the Participant Choice form is completed and signed by the participant, and the choice is documented on the participant's Plan of Care. This information is reviewed at least annually with the member. The option to end participant 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:

PCS services may be directed by an individual acting on behalf of the participant as well as directed by a durable power of attorney for health care decisions, a guardian, or a conservator. A participant who has been adjudicated as needing a guardian and/or conservator cannot choose to participant-direct his/her care. The participant's guardian and/or conservator may choose to participant-direct the participant's care. An adult participant's legal guardian and/or conservator cannot, however, act as the participant's paid attendant for (PCS) service. Guardians and/or conservators are not allowed to benefit financially from their interactions with the ward and/or conservator they represent (K.A.R. 30-5-302).
Each participant has an individual Person-Centered Service Plan that is developed with input from the person, an identified responsible party, and persons who know and care about the participant.
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 The Conflict of Interest Memorandum issues November 2017.https://www.kdads.ks.gov/docs/default-source/CSP/HCBS/HCBS-Policies/draft-final-policies/general-policies/conflict-of-interest-mitigation.pdf This Memorandum outlines the process for appointing a no-legal, designated representative.
At any time, the Person-Centered Service Plan is being reviewed and updated, the performance of the nonlegal representative will be reviewed to assure that the person is functioning in the best interest of the participant and a determination will be made as to any needed changes or modifications to the role of the non-legal representative.
It is the role of the MCO to assure services are provided in a manner consistent with the Person-Centered Service Plan.

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
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:

Fiscal Management Service

○ **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 will furnish Financial Management Services using employer authority model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.
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:

• Community Developmental Disability Organization (CDDO) agreement (DD only)
• 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 will be reimbursed a monthly fee per consumer directly by through the MCO billing system. The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. 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:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **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 verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment [KDHE]). Requirements include agreements between the FMS provider and the participant, Direct Support Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Support Worker time worked and payroll distribution. Additionally, the state will assure FMS provider development and implementation of procedures including, but not limited to, procedures to maintain background checks; maintain internal quality assurance programs to monitor participant and Direct Support Worker satisfaction; maintain a grievance process for Direct Support Workers; and offer choice of Information and Assistance services.

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, its 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).

(b) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by KDADS. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change. KDHE through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities.
(c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency.
(d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members, and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

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
Home Modification	☐
Financial Management Services	☒
Personal Care Services	☐
Intermittent Intensive Medical Care	☐
Health Maintenance Monitoring	☐
Medical Respite Care	☐
Specialized Medical Care	☐

☐ **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:

Independent advocacy is available to consumers, on a consumer-specific basis, who direct their services through a number of community organizations and through the Disability Rights Center of Kansas (DRC), the state's Protection and Advocacy organization. These organizations do not provide direct services either through the waiver or through the Medicaid State Plan.
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. Consumers 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 consumers.

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:

The participant has the opportunity as well as the ability to exercise responsibility in discontinuing to participant-direct if they choose to do so. If the participant chooses to discontinue to participant-direct, he/she is responsible for:
- Notify all providers as well as the FMS agency. He/she is to maintain continuous at care coverage until an agency-directed service can be put in place;
- Give ten (10) days' notice of his/her decision to the MCO Care Manager in order to allow for the coordination of services through an agency.

The duties of the MCO Care Manager are to:
- Explore other service options and complete a new choice form indicating the choice to agency-direct with the participant;
- Advocate for the participant by locating and coordinating services with provider agencies in order to meet the participant's assessed needs.

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 MCO may, if appropriate discontinue the participants choice to direct their services when, in the MCOs professional judgment through observation and documentation, it is not in the best interest of the participant to participant-direct their services. The MCO will make the recommendation to KDADS and there must concurrence on the reason to remove participant-direction and the following conditions will be compromised if the participant-direction continues:
- The health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS, and all training methods have been exhausted;
- The PCS is not providing the services as outlined on the PCS Skilled worksheet, and the situation cannot be remedied;
- The participant is at risk for fraud, abuse, neglect and exploitation
- The participant is falsifying records resulting in claims for services not rendered.

When an involuntary termination occurs, the MCO will apply safeguards to assure the participant's health and welfare remains intact and ensures continuity of care by offering the participant or family a choice of provider-managed services as an alternative. If the participant chooses the alternative provider managed services, the MCO will assess the participant's needs and coordinate services according to the individual's health and safety needs.

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	259	
Year 2	232	
Year 3	225	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 4	238	
Year 5	254	

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) will assume the cost of criminal history and/or background investigations conducted by the financial management service provider as an administrative function.

☐ **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:

☒ **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**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **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 an Eligibility Determination:

Kansas has contracted with independent assessors to conduct level of care determinations.
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.
Request for Hearing on an Adverse decision by MCO:

When an MCO makes an adverse decision that the member wants to appeal. KanCare managed care organizations (MCOs) who 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 in accordance with the requirements including, but not limited to,the Code of Federal Regulations (CFR) at 42 CFR § 431.200, 42 CFR Part 438, Subpart F, Grievance and Appeal System,Kansas Statutes Annotated (K.S.A.) 77-501 et seq., Kansas Administrative Procedures Act (KAPA), Kansas Administrative Regulations (K.A.R.), and applicable provisions of Kansas Statute 40-3228 relating to Grievance procedures,about which they must inform every member.

Each member is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. The MCO's develop, implement, and maintain a Provider Grievance, Reconsideration, and Appeal System that complies with the requirements in applicable Federal and State laws and regulations including, Kansas Statute Annotated

(K.S.A.) 77-501 et seq., Kansas Administrative Procedures Act (KAPA), and Kansas Administrative Regulations (K.A.R.).
KanCare members 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 business days of receipt, and a written response to the grievance will be given to the member within 30 business days(except in cases where it is in the best interest of the member that the resolution timeframe be extended).

All KanCare members are advised the following regarding appeals and state fair hearings:

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.

The information regarding continuance of service is available to the participant on the MCO’s notice action or the member's handbook. Members have other options for a quicker review of your appeal. Members may contact their health plan for more information.

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 (someone you do not know), assigned by the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.
• If you are not satisfied with the decision made on your appeal, you or your representative may ask for a fair hearing. It must be done in writing and mailed or faxed to:
Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

Members have the right to benefits while a hearing is pending, and can request such benefits as part of their fair hearing request.

All three MCOs will advise members of their right to a State Fair Hearing. Members do not have to finish their appeal with the MCO before requesting a State Fair Hearing.

Addressing specific additional elements required by CMS:

Individuals are informed of the Fair Hearing process during entrance to the waiver including how, when and by whom this information is provided to individuals.

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.

All instances when a notice must be made to an individual of an adverse action including: 1) choice of HCBS vs. institutional services, 2) choice of provider or service, and 3) denial, reduction, suspension or termination of service.
The state requires that all MCOs define an "action" pursuant to KanCare RFP Attachment C 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 that their application (choice of HCBS vs. institutional services) 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.

Notices of adverse action are kept at the MCO. Requests for Fair Hearings are kept at the Office of Administrative Hearings. MCOs must comply with the timeframes in the approved managed care contracts.

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 MCOs as the fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The MCO staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, 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 educated 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 TA Waiver Program Manager.

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 the types of critical events or incidents that must be reported:"

Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult 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 ham 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(b).

"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(c).

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(d)."

"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. K.S.A 39-1430(e).

- Identification of the individuals/entities that must report critical events and incidents:"

The Kansas statute (K.S.A. 39-1431) identifies mandated reporters required to report suspected abuse neglect, and exploitation or fiduciary abuse immediately to either Social and Rehabilitation Services (now the 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 department of social and rehabilitation services [now 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 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.

"• The timeframes within which critical events or incidents must be reported:

All reports of abuse, neglect, and exploitation must be reported to the Kansas Department for Children and Families immediately.

- The method of reporting:

Reports shall be made to the Kansas Department for Children and Families, by calling the Kansas Protection Report Center (a section of DCF), via their 24/7 in-state toll free number: 1-800-922-5330. 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
The other types of critical incidents that are required to be reported into the AIR system and include definitions on the AIR report form for all to see are: Elopement, Emergency Medical Care, Fiduciary Abuse, Law Enforcement Involvement, Natural Disaster, Misuse of Medications, Restraint, Seclusion, Serious Injury, Suicide, Suicide Attempt, and Other. Incidents shall be classified as adverse incidents when the event or incident brings harm, or creates the potential for harm to any individual being served by a KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, and Behavioral Health Services programs. All HCBS providers shall make adverse incident reports in accordance with the AIR policy. The AIR system is open faced, so anyone can make a report by utilizing the link on KDADS website. The requirement is for whoever becomes aware of the adverse incident make an AIR report within 24 hours. Reporters can be family members, friends, community members, providers of services, and/or the MCO.

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 consumers and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of Person-Centered Service Plan/service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual’s service plan. The information provided by the MCOs is consistent with the state’s abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

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: Kansas Department for Children and Families.

- The entity that is responsible for evaluating reports and how reports are evaluated.

Kansas Department for Children and Families (DCF) Intake Unit is responsible for receiving reports and determining if each report is screened in or out based on current policies identified in The Kansas Economic and Employment Support Manual [KEESM] for screening reports [12210]. If the report indicates criminal activity, local law enforcement is notified immediately."

"• The timeframes for conducting an investigation and completing an investigation.

For children, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of a child to DCF for review and follow-up. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/sexual abuse, DCF must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, DCF must respond within 20 working days. By policy, Children and Family Services (CFS) is required to make a case finding in 25 working days from case assignment."

"For adults, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of an adult to DCF for review and follow-up. K.S.A. 39-1433 establishes time frames for personal visits with involved adults and due dates for findings for DCF investigations. This statute identifies the following:

1. Twenty-four (24) clock hours if the involved adult’s health or welfare is in imminent danger.
2. Three (3) working days if the involved adult has been abused but is not in imminent danger.
3. Five (5) working days if the adult has been neglected or exploited and there is no imminent danger." "• The entity that is responsible for conducting investigations and how investigations are conducted.

Kansas Department for Children and Families is responsible for contacting the involved adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

1. Interview the involved adult. If the involved adult has a legal guardian or conservator, contact the guardian and/or conservator.
2. Assess the risk of the involved adult.
3. The APS/CPS social worker should attempt to obtain a written release from involved adult or their guardian to receive/review relevant records maintained by others."

- The process and timeframes for informing the participant including 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.

2540 Notice of Department Finding:"

The Notice of Department Finding for family reports is CFS 2012. The Notice of Department Finding for facility reports is CFS 2013. 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 persons information regarding the appeal process. The following persons must receive a notice:

The parents of the child who was alleged to have been maltreated

- The alleged perpetrator
- child, as applicable if the child lives separate from the family
- Contractor providing services to the family if the family is receiving services from a CFS contract
- The director of the facility or the child placing agency of a foster home if abuse occurred in a facility or foster home

The Notice of Department Finding shall be mailed on the same day, or The next working day, as The case Finding decision, The date on The case Finding CFS-2011"

"All case decisions/findings shall be staffed with the APS Supervisor/designee and a finding shall be made within (30) working days of receiving the report [K.S.A. 39-1433(a)(3)].

KEESM [12360] allows for joint investigations with KDADS licensed facilities per the option of the DCF Service Center and the facility. Joint investigations require a Memorandum of Agreement between the DCF Service Center and the facility which must be approved by the DCF Central Office APS Attorney. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff."

KDADS receives the initial Adverse Incident Report in the system. Program Integrity Staff utilize information from the

report to locate the member in the MMIS system which has the most updated and accurate Medicaid information. KDADS will determine if the report is a Substantiated or Unsubstantiated Adverse incident (see definitions below), assign a level (levels also defined below) and then assign the report to the MCO within one business day of receipt of the report. Once the report is assigned, the MCO is required to complete follow-up measures and resolve the adverse incident. Once the MCO 'resolves' the adverse incident, it is returned to KDADS for final review and approval or Corrective Action Plan to address any outstanding issues. The definitions for KDADS Substantiated and Unsubstantiated and Levels are provided below:

SUBSTANTIATED: If the adverse incident report is a confirmed adverse incident, KDADS will determine if further remediation is required. Note that even if no action may be required (e.g., death by natural causes, law enforcement/emergency medical involvement where no suspected Abuse, Neglect, or Exploitation is documented, etc.), all substantiated adverse incident reports are reviewed by KDADS for approval prior to marking the case as closed in the AIR system.

If an incident of restraint, seclusion or restrictive intervention requires follow-up, KDADS will complete the following steps:

- Follow up with the MCO to verify any questions KDADS staff may have.
- Require MCO to follow up with the appropriate provider to provide additional information, such as cause, circumstances, etc., following all requirements as stated in the Waiver Manual specific to the program in which the recipient is enrolled.
- MCOs must submit a summary of findings of the investigation.

UNSUBSTANTIATED: If the adverse incident report is not an adverse incident by definition, KDADS will determine if any follow up is required (e.g., reasons why the reporting party felt this was an adverse incident). If no follow up is required, then the case will be marked as an unsubstantiated report and closed in the AIR system. The process ends when the case is closed in the AIR System. All unsubstantiated adverse incident reports must be reviewed by the Program Integrity and Compliance Specialists for approval prior to marking the case as closed in the AIR system.

If the report is SUBSTANTIATED KDADS will determine the level of severity for each substantiated adverse incident reported in the AIR system using the following guidelines:

- Level 1 – Deficiencies that are administrative in nature or related to reporting no direct impact on service delivery (e.g., fall without an injury, not due to negligence by the provider or MCO). The responsibility largely falls to the MCO for follow up and remediation and KDADS will track MCO progress. Notify the MCO via the AIR system.

- 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 (only those incidents involving injury requiring medical care, unexpected deaths, unauthorized use of restraints, restrictive interventions or seclusion, abuse, neglect, exploitation). The KDADS Program Integrity and Compliance Specialists have responsibility for follow up with the MCOs on remediation efforts and resolution, but should make the appropriate Program Managers aware of the issues, as needed.

After determining the level of severity, the KDADS will determine if the incident should require a Corrective Action Plan (CAP). Corrective Action Plans are also assigned levels, which are defined the same as above. In the event the incident requires further discussion with the MCOs, KDADS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. Program Managers will determine the appropriate KDADS parties to attend the meeting depending on the nature of the incident being discussed.

Once adverse incidents are assigned to the correct MCO, the MCO has 30 days to complete all follow-up measures. The MCOs will document their follow-up measures, complete the report and send back to KDADS Program Integrity to review, approve, and/or issue a corrective action plan to address any one time, or systemic issues. Monthly reports will be generated and trends discussed internally and with each respective MCO.

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.

KDADS is the entity responsible for overseeing the operation of the incidence management system called Adverse Incidence Reporting (AIR) system. Kansas Department for Children and Families, Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an on-going basis."
"• The methods for overseeing the operation of the (AIR) system, including how data are collected, compiled, and used to prevent re-occurrence.
The KDADS Quality Program Manager is responsible for reviewing the incidences reported to AIR and assigning incident to appropriate KDADS field staff for discovery, follow up and remediation. The Quality Program Manager and the DCF Adult Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS CSP Director and the State Medicaid Agency."
"The KDADS quality team is responsible for reviewing reported critical incidents and events. The data is collected and compiled, trended by waiver population so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement/ remediation strategies to reduce future occurrence of critical incidents or events. This information will also be a monitoring, reporting and follow up element of the comprehensive KanCare quality improvement

strategy, managed the KanCare QI Strategy process to support overall quality improvement activities for the KanCare program."

KDADS conducts reviews on a quarterly basis to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education."
MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident.Currently, DCF shares all APS determinations (Screened Out, Unsubstantiated and Substantiated) and Child Protective Services (CPS) provides intakes and screen-outs via the Community Support Services Protection Report Center (CSSPRC) mailbox. The reports received from DCF to the CSSPRC mailbox will be manually entered into the AIR system until the auto feed between DCF and AIR goes live. KDADS Program Integrity Staff monitor assigned counties and forward Substantiated reports to the corresponding waiver program manager, MCO Program Integrity/Quality Staff. Once the auto feed is complete all DCF reports will automatically be entered into AIR and Abuse, Neglect and Exploitation will only need to be reported to DCF. All DCF reports entered into AIR either manually or by auto feed will go through the same process as all other adverse incidents (verify info, assign to correct MCO for follow-up/remediation, and final review/remediation is done by KDADS). The AIR system will allow for all necessary parties to be notified.

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:

• The state agency (or agencies) responsible for overseeing the use of restraint or seclusion and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue."
• Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restraint or seclusion and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the consumer's knowledge, ability and freedom from the use of restraint or seclusion. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods."
"• How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re- occurrence.

KDADS Field Staff conduct quarterly reviews with the consumer and his/her informal supports and paid staff supports to ensure there is no use of restraint or seclusion. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.
"In the event of a discovery of inappropriate use of restraints and seclusion, KDADS quality team has primary oversight responsibility of critical incidents related to safeguards concerning restraints and restrictive interventions. However, the MCO will have access to the information on AIR and KDADS will reach out to MCO and notify MCO of incident as appropriate and necessary.

- The frequency of oversight is continuous and ongoing

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.
Any use of restraints on a TA waiver member is unauthorized. All Restraints and Seclusions are required to be reported to the AIR system. Upon assignment KDADS and the MCO must identify if the use followed all requirements indicated in the Waiver Manual specific to the program in which the recipient is enrolled. If restraint, seclusion or restrictive intervention is utilized for a member receiving services under the TA waiver, this will automatically result in an unauthorized use. Utilization of any restraint, seclusion, or restrictive intervention that is not approved by the waiver will result in a Corrective Action Plan.

○ **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:

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

• The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.
• Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts quarterly reviews to educate and assess the consumer's knowledge, ability and freedom from the use of unauthorized restrictive interventions. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy."
• How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re- occurrence.

KDADS Field Staff conduct quarterly reviews with the consumer and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restrictive interventions. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy."
In the event of a discovery of inappropriate use of restraints and seclusion, KDADS quality team has primary oversight responsibility of critical incidents related to safeguards concerning restraints and restrictive interventions. However, the MCO will have access to the information on AIR and KDADS will reach out to MCO and notify MCO of incident as appropriate and necessary.

The frequency of oversight: Continuous and ongoing.
The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed.
The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.
Any use of restraints on a TA waiver member is unauthorized. All Restraints and Seclusions are required to be reported to the AIR system. Upon assignment KDADS and the MCO must identify if the use followed all requirements indicated in the Waiver Manual specific to the program in which the recipient is enrolled. If restraint, seclusion or restrictive intervention is utilized for a member receiving services under the TA waiver, this will automatically result in an unauthorized use. Utilization of any restraint, seclusion, or restrictive intervention that is not approved by the waiver will result in a Corrective Action Plan.

○ **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 state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that the state's safeguards are as followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue."
• Methods for detecting unauthorized use, over use or inappropriate, ineffective use of seclusion and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of seclusion. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive
methods.
• How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-
occurrence.
"KDADS Field Staff conduct quarterly, on-site, in-person quality reviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of seclusion. Additionally, KDADS Field staff review planning for each participant to ensure appropriate supports and services are in place to eliminate the need for seclusion. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

• The frequency of oversight: Continuous and ongoing
The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.
Any use of restraints on a TA waiver member is unauthorized. All Restraints and Seclusions are required to be reported to the AIR system. Upon assignment KDADS and the MCO must identify if the use followed all requirements indicated in the Waiver Manual specific to the program in which the recipient is enrolled. If restraint, seclusion or restrictive intervention is utilized for a member receiving services under the TA waiver, this will automatically result in an unauthorized use. Utilization of any restraint, seclusion, or restrictive intervention that is not approved by the waiver will result in a Corrective Action Plan.

○ **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 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 waiver participants whose person-centered 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 =
☒ **Other** Specify: Managed Care Organizations	☐ **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 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%
☒ **Other** Specify: 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 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 as in the approved waiver 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: 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 the follow-up methods as specified in the approved waiver D=Number of 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 waiver participants who have a 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%
☒ **Other** Specify: 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 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 reported adverse incidents for which review / investigation followed the appropriate policies and procedures N=Number of reported adverse incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported adverse incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Management System

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(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 MCO's	☐ **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	☒ **Annually**

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

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 as specified in the approved waiver D=Number of participants' 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 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 MCO's 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 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 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 =
☒ **Other** Specify: KanCare 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 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 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 =

☒ **Other** Specify: KanCare Managed Care Organizations	☐ **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 Managed Care Organizations participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 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:
Records 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%
☒ **Other** Specify: KanCare MCO's	☐ **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:

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.

Collaboration between the KDADS Field Staff and DCF-APS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with TA waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts quarterly reviews to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined there is suspicion of Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.
DCF's Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Adult Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.
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. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan 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.

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.

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 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.

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 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.
KDADS reviews a statistically significant sample of participants for the Technology Assisted (KS.4165) waiver population and the other affected waiver populations under the Quality Improvement Strategy. These include the Frail Elderly (KS.0303), I/DD (KS.0224), Physical Disability (KS.304), Serious Emotional Disturbance (KS.0320), Autism (KS.0476) and TBI waiver population (KS.4164) waiver populations. The sampling will be done for each waiver individually as will all of the data aggregation, analysis and reporting.
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 the KanCare interagency monitoring team, and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties.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' Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review 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, but are not limited to, 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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Other** 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 participant 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 DXC 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 DXC staff to generate recommended systems changes, which are then monitored and analyzed by the fiscal agent 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.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state’s Quality Improvement Strategy:
Quarterly and as needed, KDHE and KDADs will meet monthly in their LTC meeting, to evaluate trends reflected in the HCBS Quality Review Reports and 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.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. KDHE and KDADS oversees the MCOs. The MCOs are responsible for claims payment and recoupment. The MCOs are responsible for the member's Person Centered Service Plan which authorizes the HCBS services. Claims for the fully authorized services are adjudicated in accordance with the claims processing guidelines and applicable Member due process rights. The MCOs are responsible for conducting financial audit activities of claims payment. The State undergoes a yearly Single State Audit by a private contractor hired by the Kansas Legislative Research Dept. Part of the audit contains an in-depth review of the MCOs' claims data. CMS receives from the contractor a yearly complete audit report. CMS reviews the audit,and issues findings in which the agencies develop processes and procedures to address and close audit findings.
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/reviewes/member safeguards.) 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, efficience, and coordination of care, and the cost of care. The loading of capitation payments in the MMIS are reviewed for accuracy every 6 months by the KDHE finance team. This is a 100% review. Monthly, the KDHE finance team reviews the payment to MCOs against 834 file.

In addition, these services - as part of the comprehensive KanCare managed care program - will be 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.

Personal care services are provided only by qualified individuals in an eligible setting.

The MCOs can only credential providers who meet the following qualifications.
Participant-Directed
1. Be at least eighteen years of age; or
2. Must have a High School Diploma or equivalent;
3. Have the necessary training or skills in order to meet the needs of the participant.
4. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider, acting as an administrative agent on behalf of the participant.
5. Medicaid enrolled provider, contracted and credentialed with KanCare MCO
All staff must be in compliance with the KDADS' Background Check Policy. Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for

reimbursement of services under Medicaid funding.
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs verify provider qualifications.
Agency Directed
Licensed Home Health Agency
Certified Home Health Aide in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.
a) Must have a high school diploma or equivalent;
b) Must be at least eighteen years of age or older;
c) Must meet the agency's qualifications;
d) Must reside outside of waiver recipient's home;
e) 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 to provide HCBS TA waiver services.
f) Must meet KDADS approved skill training requirements
All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS training and professional development requirements; All staff must be in compliance with the KDADS' Background Check Policy. All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS training and professional development requirements;
Kansas Department of Health and Environment (KDHE), through the state fiscal agent, and the KanCare MCOs verify provider qualifications.
2. such individuals only provide the services to eligible participants with the frequency, amount, and duration specified in the plan of care;
As part of the quarterly record review, quality management staff review service plans based upon the performance measures outlined in the waiver.
Additionally, the MCOs are responsible for ensuring care coordinators are trained and knowledgeable in the person-centered service planning specific to the applicable waiver.

The MCOs are responsible for claims payment and recoupment. The MCOs are responsible for the member's Person Centered Service Plan which authorizes the HCBS services. Claims for the fully authorized services are will be adjudicated in accordance with the claims processing guidelines and applicable Member due process rights.

The MCOs are responsible for conducting financial audit activities of claims payment.
The loading of capitation payments in the MMIS are reviewed for accuracy monthly by the KDHE finance team.

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 (Division of Health Care Finance) 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 within two (2) working days 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.
KDADS has a Program Integrity Unit that assists with monitoring fiscal integrity of personal care services. EVV data is readily available and drives corrective action activities. There is a new reporting process administered through an Adverse Incident Reporting (AIR) system. This system is used to alert and track alleged incidents of fraud, waste and abuse. Referrals are made to the Kansas Attorney General for further investigation.

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:
DSS/DAI 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 =*
☒ ***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 the 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 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:
DSS/DAI 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 =*
☒ ***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 Managed Care Organizations (MCOs) participate in the analysis of this measure's resulsts as determined by the State operating agency*	☒ ***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:N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS,D=Total number of capitation (payment) rates.

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
Rate-setting documentation

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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***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 a KanCare Interagency Coordination and Contract Monitoring (KICCM) 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 Interagency Monitoring Team that engages program management, contract management and financial management staff of both KDHE and KDADS.KDADS HCBS Program Managers participate in monthly LTC meetings with KDHE. Program Managers also work with the KDADS Quality team on quarterly monitoring developing remediation for LOC Assessors and MCO's.

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 quality assurance strategy which is regularly reviewed and adjusted.
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.KDADS HCBS Program Managers participate in monthly long-term care (LTC) meetings with KDHE, and work with the KDADS Quality team on quarterly monitoring developing remediation for LOC Assessors and MCOs. Program Managers send out template for LOC assessors or MCO's to complete for Performance Measures that fall below 87% compliance. The assessor agency or MCO must complete the template with their remediation plan and return to the HCBS Director. Program Manager's review and accept or deny the plan and track progress on the remediation plan meeting compliance and continuously monitor for needed adjustments to meet remediation targets.

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:* *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 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.

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 resulting rates are certified to and approved by CMS.

The current rates are distributed by KDHE via provider bulletins. The most current rate information can be viewed at this web site: https://www.kmap-state-ks.us/Public/bulletins/bulletinsearch.asp by searching for Bulletin Number 18114. This has been corrected in the renewal application.
Providers receive notification of the published bulletins at the time they are published. Providers have the ability to contact the fiscal agent or the MCO and obtain provider bulletins. Bulletins are written in conjunction with the MCOs when the content of the bulletin impacts all MCOs. All claims in the MMIS are edited by eligibility and assignment of the member.

For a Medicaid recipient (for example a Native American) who has chosen to not enroll in the MCO the claim would pay. The claim would be submitted to the fiscal agent and pay as an FFS claim. The MMIS contains edits for eligibility and assignment. A Medicaid recipient not in an MCO would have a population code of "TA" and an assignment of FFS.

In accordance with Section 5006 of the American Recovery and Reinvestment Act (ARRA) of 2009 we recognize rights of American Indian/Alaska Native (AI/AN) to opt out of Managed Care and will be submitting an amendment to CMS no later than October 2019 that describes in detail the rate methodology and associated processes for FFS claims.

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:*

The MCO receives an 834 file from the Kansas Medicaid fiscal agent noting the member's eligibility. There is an indicator on the file noting the member's eligibility level of care. Prior authorization processes ensure services of an appropriate scope, frequency, and duration is part of the approved Person-Centered Service Plan before payment is made.
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. The MMIS has an edit to deny claims based on a member's eligibility and assignment. All claims in the MMIS are edited by eligibility and assignment of the member.
All claims in the MMIS are edited by eligibility and assignment of the member.

For a Medicaid recipient (for example a Native American) who has chosen to not enroll in the MCO the claim would pay. The member's assignment would be FFS.

The FFS pay schedule is located on the KMAP website. Providers are able to search codes and see the rate assigned to the code. If and when the fee schedule is updated in the MMIS, providers are notified through the KMAP bulletin process. Claims are paid on the date of service specific to the fee schedule in place.

Claims submitted to the fiscal agent process through the MMIS claim engine. Claims are edited for a Medicaid recipient's eligibility, assignment, Person-Centered Service Plan, provider type /specialty, prior authorization (if required), procedure and claim coding which cycle through the CMS approved state specific CCI edits.

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 KAECES, the State's eligibility system (MMIS). 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 Person-Centered Service Plan detailing authorized services. All mandated services must be billed through the EVV system. In the EVV system, specific and unique business rules are set in the system for each service the EVV system. Claims are created by a worker's Check-In/Check-Out for the service. If authorized units approved on each plan of care are not there to justify the claim, or if authorized units are exhausted during the service visit, the claim is marked with a Critical Exception. A provider is unable to confirm the claim for export to the payer for adjudication. Authorized units set monthly by approved plans of care are electronically monitored by the EVV system. Unauthorized claims never reach the payer for payment thus meeting the definitions of both pre-payment control and service plan monitoring. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1. Prior authorization processes ensure services of an appropriate scope, frequency, and duration is part of the approved plan of care before payment is made.
The waiver includes a performance measure that assesses the number of waiver participants who received services in the type, scope, amount, duration and frequency specified in the service plan. KDADS quality staff read the MCO care coordinator log notes to see if anything states the participant didn't get a service that is outlined on their service plan (i.e. Nursing). If it is not addressed the case notes, the case is marked as non-compliant.

If compliance thresholds drop below 87 percent, the MCO is required to submit a corrective action plan to KDADS.The Medicaid Management Information System (MMIS) verifies an individual is eligible for Medicaid payment on the date of service.

Claims submitted to the fiscal agent process through the MMIS claim engine. Claims are edited for a Medicaid recipient's eligibility, assignment, Plan of Care, provider type /specialty, prior authorization (if required), procedure and claim coding which cycle through the CMS approved state specific CCI edits. If upon a retrospective audit if claims were determined to be inappropriately billed, the recoupment process would be initiated which remove these claims from FFP reimbursement.

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:

- ○ ***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:

The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.

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:

☒ ***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:

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:

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

- ( ) ***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.

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 Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment(KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange SMART 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. KDHE – Division of Health Care Finance 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 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: Hospital

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	46631.29	38086.00	84717.29	313357.00	23423.00	336780.00	252062.71
2	46631.29	38086.00	84717.29	325547.00	24334.00	349881.00	265163.71
3	46631.29	38086.00	84717.29	338211.00	25281.00	363492.00	278774.71
4	46631.29	38086.00	84717.29	351367.00	26264.00	377631.00	292913.71
5	46631.29	38086.00	84717.29	365035.00	27286.00	392321.00	307603.71

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:
		Hospital

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:
		Hospital
Year 1	*543*	*543*
Year 2	*543*	*543*
Year 3	*543*	*543*
Year 4	*543*	*543*
Year 5	*543*	*543*

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 (LOS) was calculated by using a three-year average of the total days of waiver coverage. The LOS was estimated by dividing 168,108 (the average number of days of waiver coverage) by 543 (the average number of consumers receiving TA waiver services). The average length of stay is 310 days.

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 was estimated by utilizing data from the Kansas MMIS system and reflects MCO payments to the providers, using a three-year average. This will only be a projection of MCO encounters and not be reflective of the State's Capitation payments made to the MCO.

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' was projected by obtaining a three-year average of TA waiver capitation costs minus a three-year average of MCO encounter payments made to providers.

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:*

The TA Waiver receives participant referrals primarily from NICU graduates and VLBW infants who no longer require acute hospitalization. The Institutional Equivalent Consumer cost was calculated utilizing data from: Rogowski, Jeannette. "Measuring the Cost of Neonatal and Perinatal Care", Pediatrics 1999; 103; e329. Page 333 Table 1, Median Treatment Costs…for Low Birth Weight Babies ($213,945 per year) with a 3.89% inflation rate each year thereafter.

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:*

The acute care cost was estimated using data from Rogowski, Jeannette. "Measuring the Cost of Neonatal and Perinatal Care" - Ibid, Table II, Median Ancillary Costs for Low Birth Weight Infants., ($15,992 per year) with a 3.89% inflation rate each year thereafter.

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	
Medical Respite Care	
Personal Care Services	
Financial Management Services	
Health Maintenance Monitoring	
Home Modification	
Intermittent Intensive Medical Care	
Specialized Medical Care	

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
Medical Respite Care Total:							138219.08
Medical Respite Care	☒	15 minutes	84	235.74	6.98	138219.08	
Personal Care Services Total:							3389115.89
Personal Care Services - Agency-Direct	☒	15 minutes	4	1280.83	4.26	21825.34	
Personal Care Services -	☒	15 minutes	221	4589.34	3.32	3367290.54	

GRAND TOTAL:	25320790.64
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	543
Factor D (Divide total by number of participants):	46631.29
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Self-Direct							
Financial Management Services Total:							**248057.40**
Financial Management Services	☒	per month	235	9.19	114.86	**248057.40**	
Health Maintenance Monitoring Total:							**180.45**
Health Maintenance Monitoring	☒	per visit	3	2.13	28.24	**180.45**	
Home Modification Total:							**31705.30**
Home Modification	☒	per service	5	1.64	3866.50	**31705.30**	
Intermittent Intensive Medical Care Total:							**2741.04**
Intermittent Intensive Medical Care	☒	15 minutes	14	14.46	13.54	**2741.04**	
Specialized Medical Care Total:							**21510771.48**
Specialized Medical Care	☒	15 minutes	412	6933.68	7.53	**21510771.48**	

GRAND TOTAL:	**25320790.64**
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**543**
Factor D (Divide total by number of participants):	**46631.29**
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310

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
Medical Respite Care Total:							**138219.08**
Medical Respite Care	☒	15 minutes	84	235.74	6.98	**138219.08**	
Personal Care Services Total:							**3389115.89**
Personal Care Services - Agency-Direct	☒	15 minutes	4	1280.83	4.26	**21825.34**	
Personal Care Services - Self-Direct	☒	15 minutes	221	4589.34	3.32	**3367290.54**	
Financial Management Services Total:							**248057.40**
Financial Management Services	☒	per month	235	9.19	114.86	**248057.40**	
Health Maintenance Monitoring Total:							**180.45**
Health Maintenance Monitoring	☒	per visit	3	2.13	28.24	**180.45**	
Home Modification Total:							**31705.30**
Home Modification	☒	per service	5	1.64	3866.50	**31705.30**	
Intermittent Intensive Medical Care Total:							**2741.04**
Intermittent Intensive Medical Care	☒	15 minutes	14	14.46	13.54	**2741.04**	
Specialized Medical Care Total:							**21510771.48**
Specialized Medical Care	☒	15 minutes	412	6933.68	7.53	**21510771.48**	

GRAND TOTAL:	**25320790.64**
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**543**
Factor D (Divide total by number of participants):	**46631.29**
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310

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
Medical Respite Care Total:							138219.08
Medical Respite Care	☒	15 minutes	84	235.74	6.98	138219.08	
Personal Care Services Total:							3389115.89
Personal Care Services - Agency-Direct	☒	15 minutes	4	1280.83	4.26	21825.34	
Personal Care Services - Self-Direct	☒	15 minutes	221	4589.34	3.32	3367290.54	
Financial Management Services Total:							248057.40
Financial Management Services	☒	per month	235	9.19	114.86	248057.40	
Health Maintenance Monitoring Total:							180.45
Health Maintenance Monitoring	☒	per visit	3	2.13	28.24	180.45	
Home Modification Total:							31705.30
Home Modification	☒	per service	5	1.64	3866.50	31705.30	
Intermittent Intensive Medical Care Total:							2741.04
Intermittent Intensive Medical Care	☒	15 minutes	14	14.46	13.54	2741.04	
Specialized Medical Care Total:							21510771.48
Specialized Medical	☒	15 minutes	412	6933.68	7.53	21510771.48	

GRAND TOTAL:	25320790.64
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	543
Factor D (Divide total by number of participants):	46631.29
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care							
				GRAND TOTAL:			25320790.64
				Total: Services included in capitation:			25320790.64
				Total: Services not included in capitation:			
				Total Estimated Unduplicated Participants:			543
				Factor D (Divide total by number of participants):			46631.29
				Services included in capitation:			46631.29
				Services not included in capitation:			
				Average Length of Stay on the Waiver:			310

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
Medical Respite Care Total:							138219.08
Medical Respite Care	☒	15 minutes	84	235.74	6.98	138219.08	
Personal Care Services Total:							3389115.89
Personal Care Services - Agency-Direct	☒	15 minutes	4	1280.83	4.26	21825.34	
Personal Care Services - Self-Direct	☒	15 minutes	221	4589.34	3.32	3367290.54	
Financial Management Services Total:							248057.40
Financial Management Services	☒	per month	235	9.19	114.86	248057.40	
Health Maintenance Monitoring Total:							180.45
Health	☒					180.45	
				GRAND TOTAL:			25320790.64
				Total: Services included in capitation:			25320790.64
				Total: Services not included in capitation:			
				Total Estimated Unduplicated Participants:			543
				Factor D (Divide total by number of participants):			46631.29
				Services included in capitation:			46631.29
				Services not included in capitation:			
				Average Length of Stay on the Waiver:			310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Maintenance Monitoring		per visit	3	2.13	28.24		
Home Modification Total:							**31705.30**
Home Modification	☒	per service	5	1.64	3866.50	**31705.30**	
Intermittent Intensive Medical Care Total:							**2741.04**
Intermittent Intensive Medical Care	☒	15 minutes	14	14.46	13.54	**2741.04**	
Specialized Medical Care Total:							**21510771.48**
Specialized Medical Care	☒	15 minutes	412	6933.68	7.53	**21510771.48**	

GRAND TOTAL:	**25320790.64**
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**543**
Factor D (Divide total by number of participants):	**46631.29**
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310

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
Medical Respite Care Total:							**138219.08**
Medical Respite Care	☒	15 minutes	84	235.74	6.98	**138219.08**	
Personal Care Services Total:							**3389115.89**

GRAND TOTAL:	**25320790.64**
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**543**
Factor D (Divide total by number of participants):	**46631.29**
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services - Agency-Direct	☒	15 minutes	4	1280.83	4.26	21825.34	
Personal Care Services - Self-Direct	☒	15 minutes	221	4589.34	3.32	3367290.54	
Financial Management Services Total:							248057.40
Financial Management Services	☒	per month	235	9.19	114.86	248057.40	
Health Maintenance Monitoring Total:							180.45
Health Maintenance Monitoring	☒	per visit	3	2.13	28.24	180.45	
Home Modification Total:							31705.30
Home Modification	☒	per service	5	1.64	3866.50	31705.30	
Intermittent Intensive Medical Care Total:							2741.04
Intermittent Intensive Medical Care	☒	15 minutes	14	14.46	13.54	2741.04	
Specialized Medical Care Total:							21510771.48
Specialized Medical Care	☒	15 minutes	412	6933.68	7.53	21510771.48	

GRAND TOTAL:	25320790.64
Total: Services included in capitation:	25320790.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	543
Factor D (Divide total by number of participants):	46631.29
Services included in capitation:	46631.29
Services not included in capitation:	
Average Length of Stay on the Waiver:	310