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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The Money Follows the Person (MFP) grant program ended on 6/30/17. As a result, the MFP structure for transitions from an institutionalized setting to a community setting via waiver supports was modified to become the HCBS Institutional Transitions process as indicated in policy. This process rolled qualified PRTF placements into its structure. As a result, the former reserved capacity numbers for the MFP grant program and the PRTF transitions were combined to form the basis for the new reserve capacity numbers for the HCBS Institutional Transitions. The HCBS Institutional Transition policy is available to CMS upon request.

The approved 3/1/16 amendment to the IDD waiver included a service amendment for Sleep Cycle Supports that became a service called Enhanced Care Services (ECS). All references to Sleep Cycle Supports in the previously approved waiver have been updated for the ECS language throughout this waiver.

All IDD waiver services have been updated to include the CDDO affiliation requirement, as some of the service areas didn't include that language.

Foster Care setting limitation of 2 waiver participants definition has been clarified.

Day Supports exception request process is now indicated in this section, as it was missing prior to this renewal.

Day Supports limitations have been added to exclude provider billing for services that are described in the Supported Employment services definition, scope and limitations.

Residential supports limitation section also includes a clarification to the age limitation of Children's Residential access. Residential supports limitation section also includes foster care setting limitation language.

Appendix F: Fair Hearing section has been updated with new Fair Hearing timeframes for appeals, as well as clarification for IDD assessor mailing of assessment tier 0 resulting in an adverse action for the participant.

Background check language has been updated to incorporate all changes that have been made since this last waiver amendment in 2016.

Supportive Home Care, as agency-directed Personal Care Services is now listed under Personal Care Services (PCS). The PCS service definition includes services that were previously authorized under Supportive Home Care. The provider qualifications for PCS, as an agency- directed service, have been updated to reflect changes in State law.

PCS Provider clarification language has been added to indicate that any individual providing services is at least 16 years of age, or at least 18 years of age if a sibling of the person receiving services, unless an exception to this requirement has been granted by the commission, based upon the needs of the waiver participant.

Assistive Services qualified provider pool has been expanded to include all DME providers noted in the DME provider manual as qualified providers for DME under Assistive Services. The Assistive Services service definition has been revised to clarify the two categories of DME and Home Modifications.

Updates to the Person-Centered Service planning process have been added to reflect State policy. Additional clarification on the role of the MCO versus the CDDO and TCM was also added.
The capable persons language was revised to provide clarification and to be compliant with federal and state law.

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

1. Request Information (1 of 3)

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

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

Kansas - HCBS-I/DD Waiver

C. Type of Request: renewal

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.0224
Waiver Number:KS.0224.R06.00
Draft ID: KS.008.06.00

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

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

07/01/19

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.

X **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:

X **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 State of Kansas currently operates an approved Intellectual and/or Developmental Disability (IDD) waiver that provides services to eligible children and adults. The purpose of this waiver is to provide the opportunity for innovation in providing Home and Community-Based Services (HCBS)to eligible participants who would otherwise require institutionalization in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF-IID).
Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), the goals and objectives of the waiver continue to center around providing participants, who have intellectual and/or developmental disabilities, access to services and supports which allow opportunities for choices that increase the participant's independence, productivity, integration, and inclusion in the community.
Further, this range of supports and services will be appropriated to each participant and will be provided in a manner that affords the same dignity and respect to participants with intellectual and/or developmental disabilities that would be afforded to any person who does not have a disability.
The services available through the waiver can be delivered through multiple service delivery methods. Some services require licensure and are managed by the provider. Others must be self-directed, while others may be provided through either a provider-managed or participant-directed method.
The move to integrate IDD waiver services into KanCare in 2014 did not and does not diminish the waiver's focus on independent living and participant-driven services. Participants will continue to have a choice between self-directed or agency-directed services.
Programmatic oversight and control of the IDD waiver is provided by the Kansas Department for Aging and Disability Services, Division of Community Services and Programs (KDADS). Consistent with the DDRA, KDADS contracts with Community Developmental Disability Organizations (CDDOs) across the state to implement requirements related to eligibility, access to services, and other duties as defined by the Act.

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:

KDADS sought public input at regional in-person meetings, via teleconference and other non-electronic formats. The State provided information about the posting of the draft IDD waiver in the Kansas Register, HCBS Bulletins, and News Articles. As well participants were provided information through the CDDO's, ADRC, CILS, FMS, and Care Coordinators.

Public input sessions were conducted from September 10 to September 17, 2018, to present proposed changes to the IDD waiver. Tribal notices were sent on October 26, 2018 to inform tribal leaders of the intent to renew the IDD waiver. KDADS received public comments/feedback regarding the proposed IDD waiver posted for public comment October 30-November 30, 2018.
A summary of responses to public comments/questions will be posted as an FAQ on the KDADS website.

A full copy of the Waiver was available to any interested party (e.g. participant, guardian, general public, etc.) by the individual's local CDDO, Center for Independent Living (CIL), Care Coordinator, or KDADS upon request either in writing, phone, or in-person.

The categories of public input and KDADS' responses are as follows.
1. Supportive Home Care (SHC) changing to Personal Care Services (PCS): KDADS received input from stakeholders that the change of SHC to PCS was too narrow and resulted in a service definition that was going to impact IDD participants in a negative manner. In response KDADS added the following services into the PCS service definition: supervision for health, safety and welfare; assistance and accompaniment with exercise, socialization and recreation; and assistance accessing medical care.
2. Day Supports: KDADS received input from stakeholders that the clarification added to the Day Supports limitations section results in services designed to assist with employment being excluded from Day Supports. KDADS notes that Day Supports has never been intended to assist with employment. That would be a duplication of the Supported Employment service. The clarification that Day Supports is not to duplicate Supported Employment was included to solidify the lines between Day Supports and Supported Employment. In addition KDADS added volunteer work to the supports allowed under Day Supports.
3. Conflict of Interest: KDADS received input from stakeholders about the language in the evaluations and reevaluations section regarding conflict of interest. In response KDADS clarified that no employee of the CDDO may provide direct services or case management to an IDD participant and that this requirement also applies to subcontractors that specifically perform programmatic and functional eligibility determinations. In addition, stakeholders felt the conflict of interest guidance related to service providers was unclear. In response KDADS revised the conflict of interest language and inserted the new language into each service limitation and the applicable areas in Appendix C.
4. Other comments outside the scope of the waiver: KDADS received various comments reflecting general concerns with KanCare and the performance of the MCOs. In response KDADS will send these concerns to KDHE for evaluation.

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, State Plans and Regulations

Agency: Kansas Department of Health and Environment

Address: Landon State Office Bldg-Room 900 N

Address 2: 900 SW Jackson

City: Topeka

State: **Kansas**

Zip: 66612-1220

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

Fax: (785) 296-4813

E-mail: BGraff-Hendrixson@ks.gov

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

Last Name: Morgan

First Name: Paula

Title: HCBS- IDD Program Manager

Agency: Kansas Department for Aging and Disability Services

Address: 503 Kansas

Address 2:

City: Topeka

State: **Kansas**

Zip: 66603-3404

Phone: (785) 296-0648 **Ext:** **TTY**

Fax: (785) 296-0256

E-mail: paula.morgan@ks.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Bobbie Graff-Hendrixson

State Medicaid Director or Designee

Submission Date: Jan 9, 2019

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

Last Name: Graff-Hendrixson

First Name: Bobbie

Title: Senior Manager, Contracts, State Plans and Fiscal Agent Operations

Agency: Kansas Department of Health and Environment

Address: 900 SW Jackson, Suite 900 North

Address 2:

City: Topeka

State: **Kansas**

Zip:

66612-1220

Phone:

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

Fax:

(785) 296-4813

E-mail:

Bobbie.Graff-Hendrixson@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.

- [x] **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:

This approved waiver is being renewed, not replaced. Clarifying and updated language has been included in definitions, as per the main page for this renewal. Services and service types have been modified.

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 renewal will be subject to any provisions or requirements included in the state's most recent and/or approved HCBS Statewide Transition plan. The state will implement any CMS required changes by the end of the transition period as outlined in the HCBS Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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 (KDADS)

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), as Medicaid Operating Agency (MOA)have an
interagency agreement which, among other things, indicates the following:
Specifies that KDHE is the final authority on compensatory Medicaid costs.
Recognizes the responsibilities imposed upon KDHE, as the agency authorized to administer the Medicaid program, and the importance of ensuring that KDHE retains the final authority necessary to discharge those responsibilities.
Requires KDHE to approve all new contracts, Memorandums of Understanding (MOUs), grants, or other similar documents that involve the use of Medicaid funds.
Notes that the agencies work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
Requires KDHE 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 KDHE has final approval of regulations, SPAs, and Medicaid Management Information System (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 KDHE and KDADS staff; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by KDHE, 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), KDHE ensures that KDADS performs assigned operational and administrative functions by the following means:
a.Regular meetings are held by KDHE 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 consumers 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 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 (SSMA KDHE), 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, the HCBS waiver programs have merged into comprehensive managed care.
KDHE has oversight of all portions of the programs, in collaboration with KDHE, KDADS, and the KanCare MCO contracts, including those items identified in part (a) above. The key component of that collaboration is through monitoring, an important part of the overall state's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state's KanCare 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) is guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the interagency monitoring component, which brings together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including interagency monitoring meetings – occur on a quarterly basis. While continuous monitoring is conducted, including monthly and other intervals, the aggregation, analysis and trending processes is built around that quarterly structure.

Appendix A: Waiver Administration and Operation

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

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

Community Developmental Disability Organizations (CDDOs):
CDDOs could be considered both contracted entities as well as local/regional non-state entities.
Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), KDADS contracts with CDDOs across the State to perform the following functions;
*Directly or by subcontract, serve as a single point of application of referral for services, to assist all participants with a developmental disability to have access to and an opportunity to participate in community services and;
*Provide either directly or by subcontract, services to persons with IDD, including eligibility determination and explanation of available services and service providers, and referring individuals for determination of Medicaid and/or disability eligibility determination.
*Waiver enrollment managed against approved limits: KDADS is responsible for applying the State's policies concerning the selection of individuals to enter the waiver and for maintenance of a waiting list for entrance to the waiver. The CDDOs are responsible for ensuring that the people who wish to be added to the waitlist have an accurate assessment that complies with the timeframes in KDADS' Functional Assessment and Waitlist Management policy.
The CDDOs are also responsible for data entry into the KDADS' system of record, and that KDADS is informed when a person should be removed from the waitlist due to death, a move out of state, institutionalization, voluntary removal, program and functional ineligibility, and other reasons.
*Level of care evaluation: CDDO activities include compiling and submitting to the State the information that is necessary to evaluate potential entrance to the waiver and the continuing need for the level of care that the waiver provides for participants.

Related to that data collection, the CDDOs, as the state's contracted assessing entity, conduct participant waiver assessments to determine the participant's functional eligibility and level of care, as well as options counseling, in order to capture and ensure participant choice.

Managed Care Organizations conduct Service Plan development and related service authorization, assist with utilization management, conduct provider credentialing, create and provide the 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:

State of Kansas - Department for Aging and Disability Services - Community Services and Programs Commission (KDADS).

Appendix A: Waiver Administration and Operation

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

Contracted entities, including both contracted entities/providers and the State's contracted 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 will be included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process will be interagency monitoring, including HCBS waiver management staff from KDADS.

In addition, KDHE and KDADS continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will include oversight and monitoring of all HCBS programs, the KanCare MCOs, and independent assessment contractors.

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

Included in the QIS will be ongoing assessment of the results of onsite monitoring and in-person reviews with a sample of HCBS waiver participants.

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	X	X	X
Waiver enrollment managed against approved limits	X	X	X
Waiver expenditures managed against approved levels	X	X	
Level of care evaluation	X	X	X
Review of Participant service plans	X	X	X
Prior authorization of waiver services	X	X	X
Utilization management	X	X	X
Qualified provider enrollment	X	X	X
Execution of Medicaid provider agreements	X		
Establishment of a statewide rate methodology	X	X	
Rules, policies, procedures and information development governing the waiver program	X	X	X
Quality assurance and quality improvement activities	X	X	X

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 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 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:

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 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**	X **100% Review**
X **Operating Agency**	**Monthly**	**Less than 100% Review**
Sub-State Entity	X **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):
Meeting minutes
If 'Other' is selected, specify:

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 policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency

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

Data Aggregation and Analysis:

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

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

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, 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 management strategy (or QMS) 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 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 has been operationalized, staff of the three plans have and will be engaged with state staff to ensure a strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in 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 component, 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 management strategy and the operating protocols of interagency monitoring. Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality management 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			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
X **Intellectual Disability or Developmental Disability, or Both**					
	X	**Autism**	5		X
	X	**Developmental Disability**	5		X
	X	**Intellectual Disability**	5		X
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

The criteria for IDD program and functional eligibility are as follows:

1.Must be 5 years of age or older;
2.Have Intellectual Disability that began before the age of 18;
3.Have a diagnosis of a Developmental Disability that began before the age of 22;
4.Must be determined program eligible by the Community Disability Determination Organization;
5.Meet the Medicaid long-term care institutional threshold score using the State's functional eligibility instrument;
6.Be financially eligible for Medicaid
7.Be a resident of the State of Kansas

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:

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	9193
Year 2	9193
Year 3	9193
Year 4	9193
Year 5	9193

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	9004
Year 2	9004
Year 3	9004
Year 4	9004
Year 5	9004

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	
Temporary Institutional Stay	
Children coming into the custody of the Department of Children and Families (DCF)	
Children determined to be no longer eligible for the Autism (AU) Waiver	
WORK Program Transitions	
Participants determined to be no longer eligible for the Brain Injury (BI) waiver	
HCBS Institutional Transitions	
Children determined to be no longer eligible for the Technology Assisted (TA) waiver	
Military Inclusion	

Appendix B: Participant Access and Eligibility

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

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

Temporary Institutional Stay

Purpose *(describe):*

The State reserves capacity to maintain continued waiver eligibility for participants who enter into an institution such as hospitals, ICF-IIDs or nursing facilities for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis of less than 90 days. A temporary stay is defined as a stay that includes the month of admission and two months following admission. Individuals that remain in the institution following the two-month allotment will be terminated from the IDD waiver. After 90 days, the individual may utilize the Institutional Transition process, as described in the HCBS Institutional Transition policy.

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	50
Year 2	50

Waiver Year	Capacity Reserved
Year 3	50
Year 4	50
Year 5	50

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):*

Children coming into the custody of the Department of Children and Families (DCF)

Purpose *(describe):*

KDADS will serve children who have been determined eligible for the IDD waiver who come into custody of
DCF. Access to services will be available to those children immediately in accordance with the Crisis and Exception policy. Waiver services will only be provided to those children in DCF custody living in licensed foster care living arrangements.

These waiver services will not duplicate services available under other resources. Foster parents of waiver participants cannot be the paid provider of waiver-funded supports to their foster child.

Access to services will not be available for the purpose of maintenance (including room and board) and supervision of children who are under DCF's custody.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on historical data of the average number of these individuals we would expect to apply for IDD services during a year.

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

Waiver Year	Capacity Reserved
Year 1	70
Year 2	70
Year 3	70
Year 4	70
Year 5	70

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):*

Children determined to be no longer eligible for the Autism (AU) Waiver

Purpose *(describe):*

Children who have been determined to be no longer eligible for the Autism waiver, and who have been determined to be eligible for the IDD waiver will have immediate access to the IDD waiver and will not have to be on the waiting list.

Children cannot transition from the Autism waiver to the IDD waiver unless they are determined to be no longer eligible for the Autism waiver.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data regarding the average number of children who are determined to be no longer eligible for the Autism waiver but have been determined to be eligible for the IDD waiver.

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 (2 of 4)

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

WORK Program Transitions

Purpose *(describe):*

The State reserves capacity for IDD program participants who have participated in the WORK program, in accordance with the HCBS Working Healthy/WORK Transition policy. Participants have the option to return to the program and bypass the waitlist, if the person was already on the waiver prior to beginning the WORK program.

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Participants determined to be no longer eligible for the Brain Injury (BI) waiver

Purpose *(describe):*

Participants who have been determined no longer eligible for the BI waiver, and who have been determined to be eligible for the IDD waiver, will have immediate access to the IDD waiver, and will not be placed on the waiting list, in accordance with the HCBS BI Transition policy.

Participants must be determined no longer eligible for the BI waiver in order to transition onto the IDD waiver.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data regarding the average number of participants who have been determined to no longer be eligible for the BI waiver and have been determined to be eligible for the IDD waiver.

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

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

Appendix B: Participant Access and Eligibility

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

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

HCBS Institutional Transitions

Purpose *(describe):*

The State reserves capacity for people transitioning from applicable institutional settings into the community. These approved transitions formerly occurred under the Money Follows the Person (or MFP) grant.

In addition, individuals transitioning from a Psychiatric Residential Treatment Facility (PRTF)are eligible for an institutional transition in accordance with the HCBS Institutional Transition policy. IDD waiver eligible individuals who meet criteria for transitioning from the institutional setting into the community will have immediate access to IDD services by completing the process as indicated in the HCBS Transition policy.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined based on the historical average of the number of persons who had chosen to enter the former MFP program (30 yearly), as well as the historical average of the number of persons transferring from a PRTF annually (15).

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

Waiver Year	Capacity Reserved
Year 1	45
Year 2	45
Year 3	45
Year 4	45
Year 5	45

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):*

Children determined to be no longer eligible for the Technology Assisted (TA) waiver

Purpose *(describe):*

Children who have been determined no longer eligible for the Technology Assisted waiver, and who have been determined to be eligible for the IDD waiver will have immediate access to the IDD waiver and will not be required to go on a waiting list.

Participants cannot transition from the TA waiver to the IDD waiver unless they are determined to be no longer eligible for the TA waiver.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by the historical data of the average number of persons determined to be no longer eligible for the TA waiver but have been determined eligible for the IDD waiver.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

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 to access the IDD waiver in accordance with the Military Inclusion policy.

Describe how the amount of reserved capacity was determined:

There is 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

Waiver Year	Capacity Reserved
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

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

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

- **The waiver is not subject to a phase-in or a phase-out schedule.**

  The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**

  Waiver capacity is allocated to local/regional non-state entities.

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

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

1.The IDD Program Eligibility policy establishes the criteria for IDD program eligibility.
2.The Functional Eligibility Assessments and Waitlist Management policy establishes functional eligibility criteria and the process by which eligible individuals are made active on the IDD waitlist.
3.The Crisis and Exception policy establishes the process allowing eligible individuals to apply to by-pass the waitlist.
4.The HCBS Institutional Transition policy establishes the process for allowing eligible individuals, discharging from an approved institutional setting, to access the IDD waiver.
5.The Military Inclusion policy identifies the process for eligible military participants and their immediate dependent family members to access the IDD waiver.
6.The KDADS Working Healthy/WORK policy identifies the process for individuals to access the IDD waiver from the WORK program.
7.The BI Transition policy identifies the process for eligible individuals to transition from the BI waiver to the IDD waiver.

Appendix B: Participant Access and Eligibility

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)

X **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

Parents and other caretaker relatives (42 CFR 435.110; pregnant women (42 CFR 435.116); and children(42 CFR 435.118).

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:

X **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)

X **Medically needy without spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the State plan

Select one:

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

- **Other**

Specify:

Operationally, the State will continue to calculate patient liability, or member Share of Cost, and providers will continue to be responsible for collecting it. In practice, this means the State will reduce capitation payments by the individual Share of Cost amounts. The reduction will be passed from the MCO to the provider in the form of reduced reimbursement, and the provider will be responsible for collecting the difference.
The dollar amount for the allowance is $727. Excess income will only be applied to the cost of 1915(c) waiver services.

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

- **Not Applicable**

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

Specify:

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

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

- **Medically needy income standard**

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's

Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

- **The State does not establish reasonable limits.**

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

- **Other**

Specify:

Operationally, the State will continue to calculate patient liability, or member Share of Cost, and providers will continue to be responsible for collecting it. In practice, this means the State will reduce capitation payments by the individual Share of Cost amounts. The reduction will be passed from the MCO to the provider in the form of reduced reimbursement, and the provider will be responsible for collecting the difference.
The dollar amount for the allowance is $727. Excess income will only be applied to the cost of 1915(c) waiver services.

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 an entity under contract with the Medicaid agency.

Specify the entity:

- **Other**

  Specify:

Per the Developmental Disability Reform Act, KDADS contracts with Community Developmental Disability Organizations (CDDOs) to perform level of care evaluations and reevaluations as indicated in appendix A of this application.

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:

Individuals performing initial evaluations must have a minimum of six months experience in the field of IDD, and a bachelor's degree, or additional experience in the IDD field which may be substituted for at the rate of six months of experience for each semester.

KDADS may grant exceptions to the minimal requirements on an individualized basis. It is anticipated that the only exceptions that would be granted would be for persons who do not yet have the six months of experience in the IDD field. If the exception is granted, it will be given in writing from the KDADS IDD Program Manager to the CDDO responsible for that assessor.

An exception must be requested, in writing, from the CDDO to the KDADS IDD Program Manager. If this exception is granted, the assessor shall work under the direct supervision of a qualified assessor until the new assessor has had six months of experience. KDADS will maintain a log to track granted exceptions.

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.

The criteria for IDD program and functional eligibility are as follows:
1.Must be 5 years of age or older;
2.Have Intellectual Disability that began before the age of 18;
3.Have a diagnosis of a Developmental Disability that began before the age of 22;
4.Must be determined program eligible by the Community Disability Determination Organization;
5.Meet the Medicaid long-term care institutional threshold score using the State's functional eligibility instrument;
6.Be financially eligible for Medicaid
7.Be a resident of the State of Kansas

Programmatic Eligibility shall be conducted in accordance with the KDADS IDD Program Eligibility policy. Functional eligibility shall be conducted in accordance with the KDADS Functional Eligibility Assessment and Waitlist Management Policy.

Kansas continues to contract with the University of Kansas Center for Research to establish a reliable, valid, standardized assessment instrument for the FE, IDD, PD and BI waivers. A draft of the standardized eligibility instrument has been developed based upon the InterRAI instrument. Once the eligibility instrument has been finalized, an in-depth training on the instrument will be provided to functional eligibility assessors. Kansas will implement the standardized assessment tool after receiving final approval by CMS.

The State continues to seek input from eligibility assessors, stakeholders and entities who work with HCBS populations. The MFEI- IDD Advisory Workgroup meets monthly to review the training, field testing, and outcomes of this work prior to implementation. Statewide roll-out timeframe has not been established. Kansas intends to also use data from this instrument to inform other reports, as well as to inform care planning.

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

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

  A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

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

The CDDO or its eligibility subcontractor must provide conflict-free program and functional eligibility determinations. Under no circumstance can any employee of the CDDO or any employee of the subcontractor that conducts program or functional eligibility also provide direct services or case management to the waiver participant.

Individuals presenting with reasonable indicators of meeting level of care eligibility are evaluated upon initial application for services, and then reevaluated within 365 days of their previous functional assessment, upon receiving waiver funding.

Individuals performing functional assessments are CDDO employees. With prior written approval from KDADS, the CDDO may sub-contract out the screening, but under no circumstance can the sub-contractor also provide any direct service or case management to the waiver participant.

The assessment used evaluates the individual in three domains; medical, mal-adaptive and adaptive. A variety of questions are answered in each domain and then the answers are formulated into a converted score. Results of the Level of Care Evaluation/Reevaluations are shared with the MCOs in order to create the Service Plan, and to ensure that the person's services are authorized according to current program and functional eligibility requirements.

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):*

Requirements for timely re-evaluations are a component of the State's contract with the CDDO. Both expectations and guidelines are specified in the Functional Eligibility Assessments and Waitlist Management policy.

Assurance is provided through ongoing contract monitoring, and quality reviews conducted by the State and/or MCO staff.

CDDOs have the ability to generate, from the State's assessment database, a report that gives a list of re-assessments due on a monthly basis.

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:

Electronic documentation is kept by KDADS and written and/or electronically retrievable documents are also kept by the CDDO designated to perform level of care evaluations and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	**Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: Contracted assessors and Managed Care Organizations (MCOs)	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify:	X **Annually**

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

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 (365 days)of the previous Level of Care determination. N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months (365 days)of the previous Level of Care determination. D = Number of waiver participants who received Level of Care redeterminations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency's data system: Kansas Assessment Manaagement Information System (KAMIS) or related web applications.

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

Agency		
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: Contracted Assessors	**Annually**	X **Stratified** Describe Group: Proportionate by MCO
	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify:	X **Annually**

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

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 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	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: Contracted assessors	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	**Annually**
	Continuously and Ongoing

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: Contracted assessors	**Annually**	X **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:
Assessor and Assessment Records

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
State Medicaid Agency	**Weekly**	X **100% Review**
X **Operating Agency**	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
X **Other** Specify: Contracted assessors	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	**Quarterly**
X **Other**	X **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:

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 functional eligibility contractors 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 state interagency monitoring which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of interagency monitoring.

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**

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

Prior to the service plan development process, the participant's area CDDO informs eligible consumers, and/or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services.

This documentation ensures that K.A.R. 30-64-29 Gatekeeping requirements for information provision of all area services or supports available and rights pursuant to the DDRA are met.

Participants complete the IDD Medicaid Waiver Individual Choice form to indicate their choice of either Home and Community-Based services or services provided by an ICF-IID prior to their enrollment in either of these services. These forms are available to CMS upon request through the Medicaid agency or the operating agency.

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.

Copies are kept by the Community Developmental Disability Organization (CDDO)and by the persons or agencies designated as responsible for the performance of evaluations and reevaluations as indicated in contract.

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 participants 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 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 participants 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).

In addition, IDD waiver participants, as KanCare members, have access to comprehensive interpreter services via their chosen managed care organization.

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.

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	**Day Supports**		
Statutory Service	**Overnight Respite Care**		
Statutory Service	**Personal Care Service**		
Statutory Service	**Residential Supports**		
Statutory Service	**Supported Employment**		
Supports for Participant Direction	**Financial Management Services (FMS)**		
Other Service	**Assistive Services**		
Other Service	**Enhanced Care Service**		
Other Service	**Medical Alert Rental**		
Other Service	**Specialized Medical Care**		
Other Service	**Wellness Monitoring**		

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:

Day Habilitation

Alternate Service Title (if any):

Day Supports

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04010 prevocational services

Category 2: 04 Day Services

Sub-Category 2: 04020 day habilitation

Category 3: 04 Day Services

Sub-Category 3: 04060 adult day services (social model)

Category 4: 04 Day Services

Sub-Category 4: 04070 community integration

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*

Day Supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence or integration and participation in the community. Support for volunteer work can be authorized under Day Supports.

Day Supports also includes the provision of pre-vocational services which are aimed at preparing a participant for paid or unpaid employment but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety, as indicated in CFR 440.180.
These waiver services must be provided in person by licensed community service provider staff.
Such activities shall be appropriate for or lead to a lifestyle as specified in the participant's Person-Centered Support Plan. These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency, and resource identification and acquisition.
Day Supports are provided in a variety of settings in the community at large. Services must be provided outside of the participant's residence unless the person has been determined frail or fragile and the provider has a signed statement from the participants' physician that receiving the supports outside the home would put the participants' health at risk. This day service provision must be approved by the KDADS IDD Program Manager in writing.

Participants eligible to receive services while they remain in the home must participate in activities consistent with their Person-Centered Support Plan and to the extent possible, replicate activities in which the person would be participating if they were out of the home. Documentation of those activities must be maintained and provided upon request for review by the CDDO, MCO, KDADS and KDHE.

The state continues to review Day Service support in order to separate out Prevocational services from Day Habilitation services.

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

A.IDD Day Supports shall NOT be authorized for anyone who is an inpatient of a hospital, a nursing facility, or an ICF-IID.
B.Participants eligible for services through the local education authority shall not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before the age of 22 and a transition plan is developed by a transition team that includes a CDDO representative or the CDDO's designee.
C.Day Supports for adults are provided for individuals 18 years of age or older.
D.Participants must be out of their home a minimum of five hours per day or a total of 25 hours per week unless one of the following applies:
1.a participant operates a home-based business, or;
2.An exception request has been submitted due to participant's medical necessity or other extenuating circumstances, as described below.
3.Participants that have been granted an exception to receive Day Supports in the participant's home must participate in activities that are consistent with the participant's Person-Centered Service Plan, and the Day Supports provided must replicate the services which would normally occur outside of the home.
4.If a participant prefers to receive Day Supports outside the home less than five days per week, his/her preference and assessed need for Day Supports must be documented in the Person-Centered Service Plan.
E.To avoid overlap of services, Day Support is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
1.Pre-vocational services cannot duplicate services funded under the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).
2.Day Supports cannot bill for services that are described in the definition, scope and limitations of Supportive Employment.
F.Day Supports are an agency-directed only service.
G.In any given month, the maximum number of reimbursable units of Day Supports is 460 units. The maximum number of reimbursable units of Day Supports during the providers' defined seven-day week is 100 units. The maximum number of reimbursable units of Day Supports for any given day is 32 units.

Exception request process for Day Supports provided in the home:

1.Prior to providing the day supports in the home, the provider must request an exception through the CDDO. After review and approval by the CDDO, the CDDO shall send the request to KDADS.
2. Each CDDO-approved request sent to KDADS shall include the provider completed KDADS' template for each participant requiring this exception.
3. Exceptions can be requested under the following circumstances: medical necessity, home-based business or inclement weather.
4. Documentation requirements for medical necessity include: a physician signed statement issued within the past 6 months, Person-Centered Support Plan, and the Person-Centered Service Plan.
5.Documentation requirements for home-based business include: a description of the person's home-based business, Person-Centered Support Plan, and the Person-Centered Service Plan.
6. Documentation requirements and the process for requesting and exception due to inclement weather are detailed in the KDADS Inclement Weather policy 2013-02-01.
7.The documents shall be provided to the KDADS IDD Program Manager for review and either approval or denial of the in-home day support exception.
8. If an exception for medical necessity or home-based business is approved, the exception will be reviewed by KDADS every six months.
9. If the exception is due to medical frailty necessity , it will require a physician review and an updated physician statement signed by physician that describes the participant's current medical and physical condition shall be submitted every six (6) months for review by the CDDO, the MCO and KDADS.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Community Service Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Licensed Community Service Providers

Provider Qualifications

License *(specify):*

Licensed by KDADS consistent with K.A.R. 30-63-01 through 30-63-32.

Certificate *(specify):*

Other Standard *(specify):*

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

Consistent with the DDRA, Providers:
*Must submit policies and procedures for KDADS approval.
*All staff must be trained in medication administration and Abuse, Neglect and Exploitation.

Providers must be enrolled in KMAP; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Providers must be affiliated with the CDDO for each area in which the services will be provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Overnight Respite Care

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Overnight Respite Care is designed to provide relief for the participant's family member who serves as an unpaid primary caregiver. Respite is necessary so unpaid, primary caregivers are able to receive periods of relief for vacations, holidays and scheduled periods of time off. Overnight Respite Care is provided in planned segments and includes payment during the participant's sleep time.

A self-direct option may be chosen for Overnight Respite by the participant if the participant is not a child in DCF custody living in a licensed foster care setting. If the participant is not capable of providing self-direction, the participant's guardian, or legally appointed representative shall choose.
Overnight Respite Care may be provided in the following location(s:
*Participant's family home or place of residence;
*Licensed Foster Home;
*Facility approved by KDHE or KDADS which is not a private residence, or;
*Licensed Respite Care Facility/Home.

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

Overnight Respite care may not be provided by a participant's spouse OR by a parent of a participant who is a minor child under eighteen years of age. A delegated legal or non-legal representative may not also be paid to provide waiver services to the participant.

To avoid overlap of services, Overnight Respite is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
1. Participants who receive Overnight Respite Care services may not also receive Residential Supports or Personal Care Services as an alternative to Overnight Respite.
2. The KanCare MCOs will not allow payment for claims for both Overnight Respite Care and Enhanced Care Services on the same dates of service.

Overnight Respite Care services cannot be provided to an individual who is an inpatient of a hospital, a nursing facility, or an ICF-IID when the inpatient facility is billing Medicaid, Medicare and/or private insurance.
Room and board is not part of the cost of service unless provided as part of respite care in a facility approved by the state that is not a private residence.
A maximum of 60 nights of Overnight Respite per calendar year is allowed. Overnight Respite is billed on a daily rate (one unit equals one day).
The KanCare MCOs will not allow payment for claims for both Overnight Respite Care and Enhanced Care Services on the same dates of service.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Community Service Provider
Individual	Overnight Respite Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Overnight Respite Care

Provider Category:
Agency
Provider Type:

Licensed Community Service Provider

Provider Qualifications

License *(specify):*

Licensed by KDADS (K.S.A. 39-1801, et seq.) or by the Kansas Department of Health and Environment if the care is provided in a licensed foster care setting. K.S.A. 65-508.

Certificate *(specify):*

Other Standard *(specify):*

Must be affiliated with the CDDO for the area in which they operate.

All standards, certifications and licenses that are required for the specific field through which service is provided including professional license/certification if required; adherence to KDADS' training and professional development requirements.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A .39-2009 is not eligible for reimbursement of services under Medicaid funding.

Consistent with the DDRA, providers:
*Must submit policies and procedures for KDADS' approval
*All staff must be trained in Medication administration, and Abuse, Neglect, and Exploitation.

Providers must also enroll in KMAP; and must either contract with a KanCare MCO or be an approved out-of- network provider with a KanCare MCO.

Provider must be an affiliate of the CDDO in the area in which the services will be provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Overnight Respite Care

Provider Category:
Individual
Provider Type:

Overnight Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including professional license/certification if required and adherence to KDADS' training and professional development requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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 Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*

The scope, duration and amount of services authorized by the MCO shall be consistent with the participant's assessed need as documented in the Person-Centered Service Plan. Personal Care Services (PCS) includes supports for the participant in the following areas:
1. Activities of Daily Living (ADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy.
2. Health maintenance activities (HMA) in accordance with the Personal Care Services and Limitations policy.
3. Instrumental Activities of Daily Living (IADLs) in accordance with K.S.A 65-5115 and K.A.R. 28-51-113K.A.R. 30-5-300 and the Personal Care Services and Limitations policy.
4. Supervision to provide for the health, safety and welfare of the participant
5. Assistance and accompaniment for exercise, socialization and recreation activities
6. Assistance accessing medical care

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

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

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

Limitations:

The service must occur in the home or community location meeting the setting requirements as defined in the "HCBS Setting Final Rule."
Service provided in a home school setting must not be educational in purpose.
Personal Care Services cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services, or for transition services as outlined in the participant's Individualized Education Program (IEP).

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

PCS will be coordinated by the KanCare MCO Care Manager and arranged for, and purchased under the participant or legally responsible party's written authority, consistent with and not exceeding the participant's authorized service plan. Self-Directed PCS will be paid through an enrolled fiscal management service agency

A PCS worker may not perform any duties not delegated by the participant or participant's representative with the authority to direct services or duties as approved by the participant's physician. The PCS worker's task(s) must be identified as an authorized task or tasks as per the participant's authorized Person-Centered Service Plan and approved Person-Centered Support Plan.

PCS may not be provided by the parent or legal guardian for the minor program participant.
PCS provided to children in the custody of DCF cannot be provided by the waiver participant's foster parent as a waiver- funded service.

CMS prohibits payment to legally responsible persons who have a duty under State law to care for another person. These kinds of payment prohibitions typically include:
1.Payments to the parent (biological or adoptive) of a minor child, or the guardian of a minor child who must provide care to that child; or
2.the spouse of a waiver participant.

To avoid overlap of services, PCS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
Service plans for which it is determined that the provisions of PCS would be a duplication of services will not be approved.
PCS worker cannot perform any duties for the participant that would otherwise be consistent with the Supported Employment definition.
PCS shall not be authorized for the times a participant has Residential or Day supports authorized in the participant's Person-Centered Service Plan.
PCS shall not be authorized if the participant has authorization for both Residential and Day supports on the participant's Person-Centered Service Plan.
Participants receiving Residential supports cannot also receive PCS as an alternative for the same Residential supports, or any of the other family/individual supports. This does not prevent the conversion of Day Supports to PCS.
Participants receiving Day supports cannot also receive PCS as an alternative for the same Day supports. This does not prevent the conversion of Day supports to PCS.
PCS being provided as a self-directed alternative to Residential or Day supports cannot be provided by the legal guardian of the participant.

Prevocational, educational services, or supported employment services available to the participant through a local

educational agency under the Individuals with Disabilities Act (IDEA) or the Rehabilitation Act of 1973 are not covered.
Participants in Residential Supports can NOT also receive PCS, Enhanced Care Service or Overnight Respite Care.
A participant may have several PCS workers providing him or her care on a variety of days at a variety of times, but a participant may not have more than one assistant providing care at any given time. The State will not make payments for multiple claims filed for the same time on the same dates of service.
Minor children under the custody of DCF and living in a licensed foster care setting will not have the option to self-direct PCS services.
PCS is limited to a maximum of 12 hours per 24-hour period unless otherwise authorized by the MCO, in accordance with the Personal Care Services and Limitations policy. One unit is equal to 15 minutes.
Agency-directed and Self-Directed Personal Care Services can be combined to meet the participant's needs, but the total combination of Personal Care Services hours cannot exceed 12 hours per 24-hour period, in accordance with the Personal Care Services and Limitations policy.
The combination of Personal Care Services, Enhanced Care Services, and other HCBS program services shall not exceed a total of 24 hours of service within a 24-hour period, in accordance with the Personal Care Services and Limitations policy.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Personal Assistants
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Service

Provider Category:
Individual
Provider Type:

Individual Personal Assistants

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be at least 16 years of age, or at least 18 years of age if a sibling of the waiver participant, unless an exception to this requirement has been granted in writing by the commission, based upon the needs of the person receiving services, per K.A.R. 30-63-10 (4)(F)
A parent may not provide waiver-funded support to his/her minor child.
Providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.
Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.
Consistent with K.A.R. 30-63-10, the participant is responsible for documenting that the individual provider has received sufficient training to provide the needed service. That documentation must be provided to the CDDO.
All PCS assistants must be enrolled with an enrolled Financial Management Services (FMS) provider who is also an affiliate of the CDDO in the area in which the service will be provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Service

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License

Employees of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

All standards, certifications, and licenses that are required for the specific field through which service is provided including professional license/certification if required and adherence to KDADS' training and professional development requirements.

Certificate *(specify):*

Other Standard *(specify):*

Providers must be affiliated with the CDDO in the area in which the services will be provided.
Providers must enroll in KMAP and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect, and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.
PCS provider workers must be at least 18 years of age or have at least a high school diploma or GED.
Workers who are siblings to the participant receiving PCS services must be at least 18 years old.
A parent cannot provide waiver-funded support to his/her minor child.
Agency-Directed PCS workers:
1. An attendant who is a certified home health aide or certified nurse aide shall not perform any health maintenance activities without delegation and supervision of a nurse or physician pursuant to K.S.A. 65-1165.
2. A certified home health aide or certified nurse aid shall not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.
3. An agency shall maintain documentation of delegation by a licensed physician or nurse not employed by the agency. Agencies are responsible for ensuring appropriate supervision of delegated health maintenance activities.
4. Failing to properly supervise, direct, or delegate acts that constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols could result in discipline by the Board of Healing Arts.
Agency-directed service provision shall comport with KDADS Personal Care Services and Limitations policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08010 home-based habilitation
Category 4:	**Sub-Category 4:**
15 Non-Medical Transportation	15010 non-medical transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These supports are provided to waiver individuals who live in a residential setting and do not live with their birth or adoptive parents, or a person meeting the definition of family.
This service provides assistance with and acquisition, retention and/or improvement of skills related to activities of daily living such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.
Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to the facility required to assure the health and safety of individuals or to meet the requirements of the applicable life safety code.
All providers of Residential Supports shall be in compliance with K.A.R. 30-63-21 through 30-63-30.
Residential Supports cannot be provided in the participant's family home. However, Residential Supports may be provided to a participant in his or her own home or apartment, provided the service provider is licensed by KDADS to provide Residential Supports.

Family is defined as any person immediately related to the participant, such as parents/legal guardian, spouse, siblings, adult children, aunts, uncles, first cousins and any step-family relationships.

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

Payment for Residential Supports does not include payments made directly to members of the individuals'family. Payments will not be made for routine care and supervision which would be expected to be provided by family members or for which payment is made by a source other than Medicaid. The method by which the costs of room and board are excluded from payment for residential supports is specified in Appendix I-5.

To avoid overlap of services, Residential Habilitation is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
Room, board, and transportation costs are excluded in the cost of any IDD services except overnight facility-based respite.
Residential Supports cannot be provided to anyone who is an inpatient of a hospital, a nursing facility or an ICF-IID.
Residential Supports for adults are provided for individuals 18 years of age or older and must occur in a setting, without regard to siblings, where the person does not live with someone who meets the definition of family and are provided by entities licensed by KDADS. This setting must be ADA compliant, as well as compliant with the HCBS Settings Final Rule.

Children’s Residential supports provide direct assistance to persons in order to meet their daily living situation and serve to maintain or increase adaptive, capabilities, independence, integration and participation in the community.
Children’s Residential supports are for children who are not in the custody of DCF and who are between the ages of 5 and 21. Access to these services end on the participant's 22nd birthday.
These services are designed to serve children not in the custody of DCF in order to avoid placement in an institution or other congregate residential setting when they cannot, for whatever reason, remain in their natural families.
These services are provided outside the family home in a home which:
1.Is licensed by KDHE as a family foster home, meets all State or KDADS requirements, or is another residential setting that is approved in writing by KDADS.
2.Serves no more than two (2) children unrelated to the waiver participant, and;
3.Is located in or near the child’s home community and school so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as the child’s school and teachers, friends and neighbors, community activities, church and health care professionals.
4.Is compliant with the HCBS Settings Final Rule.

Children's Residential providers must also cooperate with the MCO, the CDDO, the school district, and any consultants in designing and implementing specialized training procedures for the participant. They must also actively participant participate in IEP development and the public-school education program, as well in the Person-Centered Support Planning and Person-Centered Service Planning processes for the participant.
Children's Residential Supports cannot be provided in a home where more than two participants funded with State or Medicaid money reside.

Residential supports may not duplicate other waiver or State Plan services.

The participant must have received a Residential Support service that was authorized on the participant’s Person-Centered Service Plan to bill the daily rate. Residential Support services cannot exceed the specific services authorized on the participant’s Service Plan. However, a provider of Residential Supports may respond to a residential crisis as prescribed by the participant’s backup plan. A crisis is defined as a situation in which the participant or participant’s representative requests assistance due to him/herself feeling unsafe, medical emergencies, mental health emergencies, and/or law enforcement involvement.

Participants of Residential Supports cannot also receive Personal Care Services, Overnight Respite, or Enhanced Care Services (ECS).

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

Participant-directed as specified in Appendix E

X **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	Community Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Agency

Provider Type:

Community Service Provider

Provider Qualifications

License *(specify):*

Licensed by KDADS consistent with K.A.R. 30-63-01 through 30-63-32 for Adult Residential Supports,or the Kansas Department of Health and Environment, as a licensed foster care setting for Children's Residential Supports.

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license/certification if required and adherence to KDADS' training and professional development requirements.

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

All providers must be an affiliate of the CDDO in the area in which the services are provided. All providers must be KMAP enrolled providers.

Consistent with the Developmental Disabilities Reform Act, Providers:
*Must submit policies and procedures for KDADS approval.
*All staff must be in compliance with the KDADS Background check policy.
*All staff must be trained in medication administration and Abuse, Neglect and Exploitation.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development

Category 2:	Sub-Category 2:
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported Employment services are ongoing support services for IDD participants to allow them to engage in competitive work in an integrated setting.
Competitive work is defined as work for which an individual is paid in accordance with the Fair Labor Standards Act.
An integrated work setting is defined as a job site that is similar to that of the general work force. Such work is supported by an activity needed to sustain paid employment by persons with IDD.
The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Completion of Vocational Rehabilitation or a letter, from DCF, stating the participant is not eligible for Vocational Rehabilitation is required prior to authorization of Supported Employment. In the event the participant is on a waiting list for Vocational Rehabilitation services, Supported Employment activities may be authorized until the point in time when Vocational Rehabilitation Services begin. Supported Employment activities shall not be authorized until the individual has applied to the local Vocational Rehabilitation Services office.

The following supported employment activities by Supported Employment agency staff are designed to assist individuals in acquiring and maintaining employment:

1.Individualized assessment.
2.Individualized job development and placement services that create an appropriate job match for the individual and the employer.
3.Ongoing support services necessary to assure job retention as identified in the Person-Centered Support Plan and Person- Centered Service Plan.
4.Training in related skills essential to secure and retain employment.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, which includes Vocational Rehabilitation (20 U.S.C., 1401 et seq.).
Transportation between the participant's residence and the employment site is included in the rate paid to providers of Supported Employment services.

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

a.FFP cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.
b.Supported Employment must be provided in a place of business or a setting that has otherwise been approved by KDADS, and is compliant with the HCBS Settings Final Rule, and Employment First State and Federal policy.
c.To avoid overlap of services, Supported Employment is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
•The IDD waiver funded Supported Employment activities must not be provided simultaneously with activities directly reimbursed by Kansas Vocational Rehabilitation Services.
d.Supported Employment cannot be provided in a sheltered work setting.
e.Supported Employment must be provided away from the participant’s place of residence.
f.Supported Employment cannot be provided to anyone who is an inpatient of a hospital, nursing facility or an ICF-IID.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Community Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:

Licensed Community Service Provider

Provider Qualifications

License *(specify):*

Licensed by KDADS consistent with K.A.R. 30-63-01 through 30-63-32.

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including professional license/certification if required and adherence to KDADS' training and professional development requirements.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Provider must be a KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.
Consistent with the Developmental Disabilities Reform Act, Providers:
*Must submit policies and procedures for KDADS approval.
*All staff must be trained in medication administration and Abuse, Neglect and Exploitation.

All providers must be an affiliate of the CDDO in the area in which the participant accesses services.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services (FMS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*

Within the self-directed model and Kansas State law, K.S.A. 39-7, 100, participants have the right to make decisions about, direct the provisions of, and control the Personal Care Services received by such individuals including selecting, training, managing, paying and dismissing of a direct support worker. Financial Management Services (FMS) is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model.

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

MCO Responsibilities
The FMS KMAP manual and State policy detail the responsibilities of the MCO, in relation to FMS.
The MCO will ensure that individuals seeking or receiving self-directed services have been informed of the benefits and responsibilities of self-direction and provide the participant with a choice of FMS providers. The choice will be presented to the individual initially at the time self-direction is chosen, annually during the creation of his/her Person-Centered Service Plan, or at any time requested by the participant or the individual directing services on behalf of the participant. The MCO is responsible for documenting the provider chosen by the individual. In addition, the MCO is responsible for informing the participant of the process for changing or discontinuing an FMS provider and the process for ending self-direction. The MCO is responsible for informing the participant or the participant's legal guardian that the participant can change to agency-directed services at any time if the participant no longer desires to self-direct his/her service(s). This service does not duplicate other waiver services. Where the possibility of duplicate provision of services exists, the participant's Person-Centered Service Plan shall clearly delineate responsibilities for the performance of activities.

FMS Provider Responsibilities
The FMS KMAP manual and State policy detail the responsibilities of the FMS provider.
FMS support is available for the participant (or the individual assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS is available to participants who reside in their own private residence or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks:
(1) Administrative Tasks and
(2) Information and Assistance (I & A) Tasks.
The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker (DSW).
The FMS provider is responsible for certain administrative functions including: 1.Verification and processing of time worked and the provision of quality assurance;
2. Preparation and disbursement of qualified DSW payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
3. Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
4. Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including:
1.Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;

2.Assistance to the participant or participant's representative in arranging for, directing and managing services;
3.Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4.Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring DSWs, managing workers, and providing effective communication and problem-solving.

Participant Responsibilities
1.Act as the employer for the DSW or designate a representative to manage or help manage DSWs. See definition of representative above.
2.Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the participant and the FMS provider
3.Establish the wage of the DSW(s)
4.Select DSW(s)
5.Refer the 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.
6.Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties,
including work schedule.
7.Provide or arrange for appropriate orientation and training of DSW(s). 8.Determine schedules of DSW(s).
9.Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the services approved within the Person-Centered Service Plan.
10.Manage and supervise the day-to-day HCBS activities of DSW(s).
11.Verify time worked by DSW(s) was delivered according to the Person-Centered Service Plan; and approve and validate time worked electronically or by exception paper timesheets.
12.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 Person-Centered Service Plan.
13.Report work-related injuries incurred by the DSW(s) to the FMS provider.
14.Develop an emergency worker back-up plan in case a substitute DSW is ever needed on short notice or as a short-term replacement worker.
15.Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
16.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.
17.Inform the FMS provider of the dismissal of a DSW within 3 working days.
18.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.
19.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 is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for DSWs. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

FMS Provider must be an affiliate of the CDDO in the area in which the service will be provided.

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

Access to this service is limited to participants who chose to participant-direct some or all of the service(s) when participant-direction is offered.
FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant.
A participant may have only one FMS provider per month.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid Provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services (FMS)

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Enrolled FMS providers will furnish FMS according to Kansas model. The provider requirements will be published and placed in the KMAP manual and/or in the KanCare MCO provider manuals and websites.

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

All standards, certifications and licenses are required for the specific field through which service is provided including: professional license / certification if required and adherence to KDADS' training and professional development requirements. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

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

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:
•Community Developmental Disability Organization (CDDO) affiliate 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.
•Including process for conducting background checks
•Process for establishing and tracking workers wage with the participant

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistive Services are those services which meet a participant's assessed need by modifying or improving a participant's home through home modifications or otherwise enhancing the participant's ability to live independently in his/her home and community through the use of adaptive equipment. For the purposes of this waiver, adaptive equipment includes durable medical equipment, van lifts and communication devices.
Durable Medical Equipment (DME)
1. All DME must be prescribed by a licensed physician or licensed therapist.
2. DME shall meet the definition in K.S.A. 65-1626.
3. DME shall meet the definition of medical necessity in K.A.R. 30-5-58.

Communication Devices
1. Devices, electronic or otherwise, that assist or enable the individual to communicate.
2. All communication devices must be recommended by a speech pathologist.
3. Communication devices are purchased for use by the individual only, not for use as agency equipment.

Van Lifts
1. Van lifts must meet engineering and safety recognized by the Secretary of the U.S. Department of Transportation.
2. Van lifts can only be installed in family vehicles or vehicles owned or leased by the participant.
3. A van lift may not be installed in an agency vehicle unless an informed, written exception is provided by the MCO.

Home Modifications
1.Home modifications may not add to the total square footage of the home except when necessary to complete the modification. Examples include increase in square footage to improve entrance/egress in a residence or to configure a bathroom to accommodate a wheelchair.
2.Home modifications may only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years and will give first rent priority to tenants with physical disabilities.
3. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. The MCO may grant an informed, written exception, but will require the agency to pay for the costs associated with the removal, transfer and re-installation of modifications to the participant's new home. Participant specific items such as portable lifts and wheelchair modifications would be covered regardless of where the participant lives.
Reimbursement for this service is limited to the participant's assessed level of service and based on the participant's Person-Centered Service Plan. All Assistive Services will be arranged by the MCO chosen by the participant, with the participant's written authorization of the purchase. Participants will have complete access to choose from all qualified providers with consideration given to the most economical option available to meet the participant's assessed needs. If a related vendor, such as a Durable Medical Equipment provider, does not wish to contract with the MCO or FMS provider, the State shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

Assistive Services are agency-directed only.

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

•All Assistive services will be purchased under the participant's or guardian's written authority and paid to the qualified entity as determined by the MCO and will not exceed the prior authorized purchase amount.
•Agencies contracted to provide home modifications include contractors and/or agencies licensed by the county or city in which they work, and they must perform all work according to the existing local building codes.
Home modifications and van lifts require at least two bids from companies that are qualified by the CDDO in writing, or who are CDDO affiliates. The bids must be submitted and reviewed prior to the approval of the prior authorization. In the event there are not two affiliated providers, the MCO shall document this in the Person-Centered Service Plan and may authorize the home modification or van lift to provide for medical necessity.
•All assistive services must have prior authorization.
•The participant or responsible party must arrange for the purchase.
•Work must not be initiated until approval has been obtained through prior authorization.
•Responsible party is defined as the participant's guardian or someone appointed by the participant or guardian who is not a paid provider of services for the participant.
•To avoid overlap of services, Assistive Service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
Purchase or rent of new or used assistive technology is limited to those items not covered under the State Plan.
DME can only be accessed after a participant is no longer eligible for EPSDT services through the State Plan.
•No outside party can be required to subsidize an Assistive Service request. The contractor must agree to accept full payment from Medicaid.

•Up to $300.00 may be approved on an annual basis to pay for the maintenance and/or repair of a previously approved Assistive Service.
•Prevocational, educational services, or supported employment services available to the participant through a local educational agency under the Individuals with Disabilities Act (IDEA) or the Rehabilitation Act of 1973 are not covered.

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

Participant-directed as specified in Appendix E

X **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: Center for Independent Living
Agency	DME: Durable Medical Equipment Provider, Home Health Agency, Pharmacy, Rural Health Clinic, and Welding Shop

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Services

Provider Category:

Agency

Provider Type:

Home Modification: Center for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Medicaid-enrolled provider
Affiliated with the CDDO
All general contractor service providers, if required, must meet the local city and state building codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years.
Providers must meet all standards, certifications and licenses that are required for the specific field through which service is provided including professional license/certification if required. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Services

Provider Category:

Agency

Provider Type:

DME: Durable Medical Equipment Provider, Home Health Agency, Pharmacy, Rural Health Clinic, and Welding Shop

Provider Qualifications

License *(specify):*

Home Health Agency License
Pharmacy License

Certificate *(specify):*

As indicated by KDHE for DME providers and Rural Health clinics.

Other Standard *(specify):*

1. As described in K.A.R. 30-5-59
2. As described in K.S.A. 65-1626
3. Medicaid-enrolled provider
4. Affiliated with the CDDO

DMS as a part of Assistive Services may be provided by all of the following:
*Licensed Home Health Agency
*Durable Medical Equipment Provider
*Pharmacy
*Rural Health Clinic (medical supplies only)
*Welding Shop (oxygen only)

Providers must meet all standards, certifications and licenses that are required for the specific field through which the service is provided including: professional license/certification if required and adherence to KDADS' training and professional development requirements.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Enhanced Care Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Enhanced Care Services (ECS) provide supervision and/or non-nursing physical assistance during a participant's normal sleeping hours in his/her place of residence. Enhanced Care Services (ECS) is available to participants who demonstrate an assessed need for a minimum of 6 hours of additional care for overnight support, during the participant's normal hours of sleep, and the assessed need cannot be met by the use of Personal Emergency Response Services (PERS), informal supports or other less restrictive services. The ECS worker must be immediately available to provide supervision or physical assistance with tasks such as toileting, transferring, mobility, and medication reminder as needed. The ECS provider must be ready and able to contact a doctor, hospital, or medical professional in the event of an emergency. ECS must be provided in the participant's home. Services providers must remain in the participant's home for the duration of this service provision in accordance with the participant's authorized Person-Centered Service Plan.

ECS can be provided as a self-directed or agency-directed service. If ECS is self-directed, the participant or designated representative is responsible for hiring, supervising, and terminating the employment of direct support workers; understanding the impact of those decisions; and assuming responsibility for the results of those decisions.

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

Enhanced Care Services must be provided in accordance with the Enhanced Care Services policy.
A statement of medical necessity, signed by a physician, must be on record with the MCO in order to authorize ECS on a participant's Person-Centered Service plan.
Only one unit (a minimum of 6 hours) is allowed within a 24-hour period.

ECS, in combination with other HCBS services, cannot exceed 24 hours within a 24-hour period.
If additional support is required, exceptions to Personal Care Service may be used to assure needed coverage up to 24 hours.

To avoid overlap of services, ECS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
1. Participants whose Person-Centered Service Plan authorizes Residential Supports cannot receive ECS.
2. ECS may not be provided when a participant's Person-Centered Service Plan authorizes PCS as an alternative to Overnight Respite.
3. ECS can be authorized as an overnight respite option to provide relief for the participant's family member who serves as an unpaid primary care giver. When ECS is utilized for the Overnight Respite option, the following criteria are applied:
ECS may not be provided by a participant's spouse OR by a parent of a participant who is a minor child under eighteen years of age.
4. The participant’s Person-Centered Service Plan must document that the Participant has an assessed need beyond what can be provided through Personal Emergency Response System (PERS).
5. ECS authorized for children in DCF custody cannot be provided by the waiver participant's foster parent as a waiver-funded service.
Overnight Respite Care and ECS may not be authorized on the same dates of service.
Participants residing in an institution, assisted living facility, residential setting or other type of group home are not eligible for ECS.
Participants in DCF custody cannot self-direct ECS.

Conflict of Interest:
ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest is mitigated as ordered by the probate court or a designated representative is appointed to direct the care of the participant.
ECS cannot be provided by a participant’s legally responsible person(spouse or parent of a minor child) or any individual residing in the home with the participant., The MCO may grant an exception to allow a legally responsible person or an individual residing in the home with the participant to provide ECS when one of the following three circumstances is present:
1) The participant lives in a rural area, in which access to a provider is beyond a 50-mile radius from the participant's residence and the relative or family member is the only provider available to meet the needs of the participant.

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

3) The participant has exhausted other support options offered by the MCO and absent ECS would be at significant risk of institutionalization.

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	Individual
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:

Individual

Provider Type:

Individual

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 the KMAP-enrolled Financial Management Services (FMS)provider, acting as an administrative agent on behalf of the participant. FMS provider must be contracted and credentialed with participant's MCO.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License
Employees of a Home Health Agency as specified in K.A.S. 65-5101 through K.S.A. 65-5117.
All standards, certifications, and licenses that are required for the specific field through which service is provided including professional license/certification if required; adherence to KDADS' training and professional development requirements.

Certificate *(specify):*

Other Standard *(specify):*

Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a KMAP provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).

Provider must be affiliated with the participant's CDDO.

1.Be at least eighteen years of age; or
2.Must have a High School Diploma or equivalent;
3.Complete KDADS' Approved Skill Training requirements, if applicable
4.Have the necessary training or skills in order to care for the participant, as requested either by the participant or participant's legal representative, qualified medical provider, or KanCare MCO.
KMAP-enrolled provider contracted and credentialed with KanCare MCO.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medical Alert Rental

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*

The purpose of this service is to provide support to a consumer who has a medical need that could become critical at any time. The medical alert device is a small instrument carried or worn by the consumer which, by the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help 24 hours a day, 7 days a week.

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

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

Rental, not the purchase, of this equipment is covered. Maintenance of equipment is included as a part of the rental agreement.
Personal Emergency Response System services must be billed at a monthly rate.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Emergency Transportation Provider
Agency	Hospital

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:
Agency

Provider Type:

Emergency Transportation Provider

Provider Qualifications

License *(specify):*

K.S.A. 65-6102 et. seq.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must also be a Medicaid or KanCare enrolled provider; and must contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

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

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

Must be an affiliate of the CDDO for the area in which the service is provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Alert Rental

Provider Category:

Agency

Provider Type:

Hospital

Provider Qualifications

License *(specify):*

K.S.A. 65-410 et. seq.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must also be a KanCare enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO. Services and equipment must conform to industry standards and any federal, state, and local laws and regulations that govern this service. The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

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

Provider must be an affiliate of the CDDO in the area in which the service is provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*

This service provides long-term nursing support for medically-fragile and technology-dependent participants. The required level of care must provide medical support for participants needing ongoing, daily care that would otherwise require the participant to be in a hospital. The intensive medical needs of the participant must be met to ensure that the participant can live outside of a hospital or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF-IID).

For the purpose of this waiver, a provider of Specialized Medical Care (SMC) must be an RN or an LPN under the supervision of an RN. Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of participants within the scope of the State's Nurse Practice Act. The service may be provided in all customary and usual community locations including where the participant resides and socializes. It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the participant.

Specialized medical care does not duplicate any other Medicaid state plan service or other services available to the beneficiary at no cost. Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the participant's Service Plan.

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

Access to Specialized Medical Care Services is limited to those recipients who's needs can only be met by an RN or LPN as determined by a needs assessment based on how often and to what extent a person needs can only be met through the use of medical technology.

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

1. Specialized Medical Care Services recipients may not also receive Residential Supports or Personal Care Services as an alternative to Specialized Medical Care Services.
2. Specialized Medical Care services furnished through the waiver are available as an “extended State plan service” for IDD participants.
3. Individuals who are eligible to receive EPSDT services may access Specialized Medical Services through the Medicaid state plan. Waiver limits do not apply to individuals receiving benefits under EPSDT.
4. Specialized Medical Care services authorized for children in DCF custody cannot be provided by the waiver participant's foster parent as a waiver-funded service.
5. Room, board and transportation costs are excluded.
6. Specialized Medical Care services may not be provided by a participant’s spouse or by a parent of a participant who is a minor child under 18 years of age.
7. A participant can receive Specialized Medical Care services from more than one worker, but no more than one worker can be paid for services at any given time of day. A Specialized Medical Care provider cannot be paid to provide services to more than one participant at any given time of day.

Specialized Medical Care services are limited to a maximum of twelve hours per day or 1448 units per month. One unit is equal to 15 minutes.
Services furnished to a participant who is an inpatient or resident of a hospital, nursing facility, ICF-IID, or IMD are not reimbursable.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Health Agency

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:

Home Health Agency

Provider Qualifications

License *(specify):*

1. A licensed LPN or Rn by the Kansas State Board of Nursing.
2. Employees of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117.

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license/certification if required and adherence to KDADS' training and professional development requirements.

All providers of Specialized Medical Care must be in compliance with K.A.R. 30-63-21 through K.A.R. 30-63-30.

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

Providers must be an affiliate of the CDDO in the area in which the services are provided.

Providers must also be a KanCare enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Wellness Monitoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11010 health monitoring
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*

Wellness Monitoring is a process whereby a registered nurse evaluates the level of wellness of a participant to determine if the participant is properly using medical health services as recommended by a physician and if the health of the participant is sufficient to maintain him/her in the participant's place of residence without more frequent skilled nursing intervention.

Wellness Monitoring includes checking and/or monitoring the following:
1. Orientation to surroundings
2. Skin Characteristics
3. Edema
4. Personal Hygiene
5. Blood Pressure
6. Respiration
7. Pulse
8. Adjustments to medication

For members who access this service, the results will be included in information shared between the member's TCM and MCO care management staff.

The Registered Nurse providing the Wellness Monitoring will not also provide any services performed by a Personal Care Services provider to prevent duplicative billing with other services authorized on the Service Plan.

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

Participants must have medical conditions that require monitoring if they are not receiving skilled nursing care.
Only one visit by a Registered Nurse, per 60 days, is covered.
A participant eligible for wellness monitoring lives in a non-institutional setting and, through the utilization of wellness monitoring is visited no more often than every 60 days, is able to maintain his/her independence at home, or in an alternative living arrangement. This service is provided by Registered Nurses only, who may be employed by home health agencies licensed by the Department of Health and Environment, KDADS licensed agencies, public health departments or Community Service Providers.

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

Direct medical intervention is obtained through the appropriate medical provider and is not funded by this program.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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 Community Service Provider
Agency	Home Health Agency

Provider Category	Provider Type Title
Agency	Public Health Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:
Agency
Provider Type:

Licensed Community Service Provider

Provider Qualifications

License *(specify):*

Provided by an RN licensed by KDADS,the Kansas Department of Health and Environment through K.S.A. 65-5101 through K.S.A.-5117, and employed by an entity licensed by KDADS.

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license/certification if required and adherence to KDADS' training and professional development requirements.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Providers must be an affiliate of the CDDO in the area in which the services are provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Wellness Monitoring

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

An RN licensed by the Kansas Department of Health and Environment consistent with K.S.A. 65-5101 through K.S.A.65-5117,
who is
2.Employee of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license/certification if required and adherence to KDADS' training and professional development requirements.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Providers must be an affiliate of the CDDO in the area in which the services are provided.

Providers must also be a KanCare enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:

Agency

Provider Type:

Public Health Department

Provider Qualifications

License *(specify):*

An RN licensed by the Kansas Department of Health and Environment consistent with K.S.A. 65-5101 through K.S.A.65-5117.

Certificate *(specify):*

Other Standard *(specify):*

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license/certification if required and adherence to KDADS' training and professional development requirements.
All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Providers must be an affiliate of the CDDO in the area in which the services are provided.

Providers must also be a Medicaid or KMAP enrolled provider; and must either contract with a KanCare MCO or be an approved out-of-network provider with a KanCare MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

- **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

X **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.*

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

Case management services for participants served on the IDD Waiver are provided by individuals employed by entities annually licensed by the Kansas Department for Aging and Disabilities Services and contracting with KanCare MCOs. These entities are also enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services. Each individual case manager is required to have met the following education and training requirements:
•Six months full time experience in a field of human services; and
•A bachelor's degree; or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of 6 months of full-time experience for each missing semester of college; and
•Successful completion of the designated case management training and assessment by scoring eighty five percent or higher on each module.
The KanCare MCOs will work with the participant, the participant's TCM and the other persons in the participant's support planning team, to assist in the development of an integrated serevice plan that addresses the service and support needs across the member's life and to assist the member in identifying and accessing services and supports beyond the I/DD waiver services. This will be a part of the KanCare MCOs' administrative functions around care management and member support within the KanCare program. The work of the KanCare MCO staff will supplement the effort of the member's IDD waiver and TCM providers.

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):

Community Developmental Disability Organizations (CDDOs), Community Service Providers (CSPs), and other affiliates shall perform background checks in accordance with the KDADS' Background Check policy, and shall comply with all regulations related to Abuse, Neglect and Exploitation.

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

CDDOs and Community Service Providers (CSPs), and other affiliates are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs, CSPs and other affiliates may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff.

Background checks are required of employees regardless of whether they are providing a licensed or non-licensed service. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings.

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):

CDDOs, CPS, and other affiliates shall perform background checks in accordance with the KDADS' Background Check policy.

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

CDDOs and CSPs, and other affiliates are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs, CSPs and other affiliates may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings.

Appendix C: Participant Services

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

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

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

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

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

Facility Type	
Licensed Foster Care Setting	
Adult Group Home	

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

Required information is contained in Attachment #2 HCB Settings of the Main Module.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Foster Care Setting

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Medical Alert Rental	
Overnight Respite Care	X
Financial Management Services (FMS)	
Residential Supports	X
Supported Employment	
Specialized Medical Care	X
Personal Care Service	X
Assistive Services	
Enhanced Care Service	X
Wellness Monitoring	
Day Supports	

Facility Capacity Limit:

No more than 2 children non-related to participant unless an exception is granted in writing by KDADS' IDD Program Manager prior to placement.

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

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Medical Alert Rental	
Overnight Respite Care	
Financial Management Services (FMS)	
Residential Supports	X
Supported Employment	

Waiver Service	Provided in Facility
Specialized Medical Care	
Personal Care Service	
Assistive Services	
Enhanced Care Service	
Wellness Monitoring	
Day Supports	

Facility Capacity Limit:

8

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

Scope of State Facility Standards

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

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

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.*

a) 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.
i. 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.

ii. 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 the participant 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's residence or the service location is so remote that PCS services would otherwise not be available to the participant if the exception was not
granted. b) HCBS Conflict of Interest policy, HCBS Personal Care Services policy and Person-Centered Service Plan policy
c) 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.

☒ **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 ECS under the following circumstances:
1.A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflicts of interest have been mitigated in accordance with K.S.A. 59-3068.
a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.

b. It shall be the responsibility for the legal guardian to provide to the MCO and FMS provider a copy of the special or annual report in which the conflict of interest is disclosed and a copy of the judge's order or approval determining that there is no conflict of interest for the guardian to be paid to provide HCBS supports for the participant.

2. If the court determines that all potential conflicts of interest have not been mitigated; or the legal guardian otherwise chooses to provide personal care services, the legal guardian shall select a designated representative, who is not a legally responsible individual for the participant, to develop the Person-Centered Service Plan and direct the participant's HCBS services.
3. An A-DPOA, who is currently authorized to make financial, medical or other decisions on behalf of the participant, is not permitted to be a paid provider unless a designated representative is appointed to direct the individual's care. 4. The MCO may grant an exception to the above listed criteria when one of the three circumstances are 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 ECS would be at significant risk of institutionalization.

The controls that are employed to ensure that payments are made only for services rendered include: MCO quarterly quality reviews to monitor that services that are provided are approved in the Person-Centered Service plan, monitoring of PCS services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

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

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

Other policy.

Specify:

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

Any qualified provider may enroll with the State‘s fiscal agent as a Medicaid provider. There is a specific department called Provider Enrollment, and an 800-telephone number is available. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written and authorized service plan.

When potential providers contact Provider Enrollment, they can request an enrollment packet that includes information such as the provider requirements for each service. This information is also available online.

The following timelines are established with regard to provider enrollment:
1.Mail provider enrollment packets within two (2) business days of request.
2.Process provider applications and updates within five (5) business days of receipt.
3.Notify providers of acceptance/rejection within ten (10) business days of receipt of the application. This notification includes information regarding the provider‘s program billing, NPI, and other information as the State may require.
4.Supply provider with SCPCS code listings within five (5) business days of request.
5.Update institutional rates on the provider master file within two (2) business days of receipt.
6.Provide minutes of provider enrollment meetings to the State within ten (10) business days.

Participants of IDD waiver services have the right to choose who provides their services, within established guidelines regarding provider qualifications. Any qualified provider of those services may enroll through the Medicaid agency, KDHE, for the Kansas Medical Assistance Program (KMAP), and also must contract with and meet the contracting terms of the KanCare
MCOs.

All IDD waiver providers must be affiliated with the CDDO in the area in which the participant resides and has services.

In addition to broad scale information and outreach by the state and the KanCare MCOs for all Medicaid providers, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition.

In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls). the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about the KanCare program; about transition planning (and specific flexibility to support this) and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to qualify have been clearly communicated via state and MCO information development and outreach as described above, and also via standardized credentialing applications and state-approved contracts which MCOs offered to each existing provider; and related information, including provider manuals have been made available via state and MCO websites.

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 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 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	**Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **Stratified** Describe Group: Proportionate by MCO

	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	**Quarterly**
X **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	X **Annually**
	Continuously and Ongoing
	Other Specify:

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:

KanCare 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	**Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **Stratified** Describe Group: Proportionate by MCO
	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**

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

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 enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of 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):*

X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	**Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **Stratified** Describe Group: Proportionate by MCO
	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	**Quarterly**
X **Other** Specify:	X **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 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	**Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify:	**Annually**	X **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:

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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	**Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **Stratified** Describe Group: Proportionate by MCO
	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	**Quarterly**
X **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	X **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 a state interagency monitoring process, 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 statewide quality improvement strategy and the operating protocols of interagency monitoring.

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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**
	X **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.

Required information is contained in Attachment #2 HCB Settings of the Main Module.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Service Plan

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

Registered nurse, licensed to practice in the State

Licensed practical or vocational nurse, acting within the scope of practice under State law

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

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

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

Specify qualifications:

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

Regarding Aetna: Service Coordinator positions require a registered nurse (RN) or an independently licensed, master's level behavioral health professional (e.g. LCSW, LPC). They are generally assigned the most complex members and may assist with clinical needs of less complex members. Service Coordination Coordinator positions require at a minimum a bachelor's degree, but a master's degree in a health care or related field is preferred. They are generally assigned to manage members whose care coordination needs may be complex, but who do not require a licensed CM or complex clinical judgment to manage (e.g., members in long term services and supports who may have multiple home and community based non-clinical service needs)

Regarding Sunflower: Care Managers have primary responsibility for ensuring service plan development. Care managers are Registered Nurses and master's level Behavioral Health clinicians with care management experience and, as applicable to the position,expertise including adult and pediatric medical, maternity and behavioral health/psychiatric care.

Regarding United: Service plans are developed by licensed nurses or licensed social workers

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

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:*

*The State employs 26 KDADS Regional Field Staff. These individuals are assigned to specific CDDO service areas around the State and are responsible for assuring that participants receive quality services. This is done through ongoing observation, monitoring and feedback of the services provided by the community service provider.
Local CDDOs are also responsible for the development and implementation of local Quality Assurance processes that include participation of providers, parents/guardians and participants of services, per K.A.R. 30-64-01 et seq. These local CDDO review committees work collaboratively with the 26 KDADS Regional Field Staff.
*The Regional Field Staff, on a quarterly basis, review the services of a sample of waiver participants through the National Core Indicators (NCI)survey process. This process identifies outcomes related to service provision and whether those outcomes are being met by the entity responsible for the provision of services.
*The Targeted Case Manager(TCM) develops a Person-Centered Support Plan based a variety of resources including the functional assessment, a needs assessment and information gathered from people who know and care about the person receiving services. The Person-Centered Support Plan is an individualized plan that identifies the needs, supports, and services necessary and are developed in partnership with the participant, and if appointed, the legal guardian, and is guided by regulation (K.A.R. 30-63-21 and K.A.R. 30-63-23)and policy.
*The participant is supported in making informed choices regarding:
*Services and supports
*Self-direction (employer and/or budget options, if available) [Participants that choose the self-direct option are provided opportunities for training to more effectively handle their self-directing responsibilities. Also, these participants are provided support in understanding the benefits / rights /limitations and the responsibilities and the potential liabilities of self-direction. Liabilities may include not having staff at all times, due to staff recruiting, retention or availability issues that are the individual‘s responsibility under self-direction.]
*Providers, agencies, and case managers. The participant is supported in making independent choices of self-direction and providers regardless of the affiliation of the case manager.
*Choice is offered to the participant at least annually, regardless of current provider or if the person has self-direction, at other life choice decision points, or any time at the request of the individual. Individuals are provided information about the full range of waiver services by CDDOs and by MCO care management staff to ensure impartial assistance of all options available.
*Choice is documented with the participant signature and date and is placed for review in the participant's case file.
*The Person-centered Support Plan and choice documentation are monitored by KDADS Regional Field staff and the KanCare MCOs as a component of waiver assurance and minimum standards.
*The Person-Centered Service Plan and Person-centered Support Plan are modified to meet change in needs, eligibility, or preferences, or at least annually.

The KanCare MCOs work with the participant, the participant's TCM, and the other persons in the participant's support planning team, to assist in the development of a service plan that addresses the service and support needs across the participant's life and to assist the participant in identifying and accessing services and supports beyond IDD waiver services. This is a part of the KanCare MCOs’ administrative functions around care coordination and participant support within the KanCare program.

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.

Case management services for participants on the IDD Waiver are provided by individuals employed by entities annually licensed by the Kansas Department for Aging and Disabilities Services that are also enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services. Each individual case manager is required to have met the following education and training requirements:
•Six months full time experience in a field of human services; and
•A bachelor's degree; or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of 6 months of full-time experience for each missing semester of college; and
•Successful completion of the designated case management training and assessment by scoring eighty five percent or higher on each module.

Consistent with the Developmental Disabilities Reform Act of 1995 and further with K.A.R. 30-63-21, the provider(s) of services shall prepare a written person-centered support plan for each person served that shall meet the following requirements.
The relevant requirements are:
1.Be developed only after consultation with the following:
A)The participant;
B)The participants' legal guardian, if one has been appointed, and;
C)Other individuals from the participants' support network as the person or the persons' guardian chooses.
2.Contain a description of the persons' preferred lifestyle.
3.The plan must list and describe the necessary activities, training, materials, equipment, assistive technology and services that are needed to assist the participant to achieve the participant's preferred lifestyle. the participant's case manager will be responsible for coordination of the plan.
All participants have the opportunity, to the extent he/she chooses, to participate in the development of his/her person-centered plan. The CDDO is responsible for informing the participant of the types of waiver services available in the CDDO area and a list of all of the providers of those services. The participant's case manager is responsible for and assisting the participant in his/her effort to meet with waiver providers to discuss how the provider can meet the participants' needs. In addition, the case manager is responsible for informing the participant of training opportunities that are available to assist the participant in becoming more active in his/her role in the planning process to the extent that he/she chooses.
Training topics would include:
•Person-centered planning models
•Self-Advocacy and;
•Rights and Responsibilities
A complete copy of K.A.R. 30-63-21 is available to CMS upon request.

The KanCare MCOs will work with the participant, the participant's TCM and the other people on the participant's support planning team, to assist in the development of an integrated service plan that addresses the service and support needs across the participant's life and to assist the participant in identifying and accessing services and supports beyond the IDD waiver services.
This will be a part of the KanCare MCOs' administrative functions around care management and member support within the KanCare program.

The Person-Centered Planning process includes the development of the Person-Centered Service Plan and the Person-Centered Support Plan, Individualized Education Plan, Behavior Management and Support Plan, Emergency Backup Plan, and other plans that are designed to identify the needs of a participant and determine the appropriate level of supports and services to meet those needs. Information from the person-centered planning process will be incorporated in the MCO's Service Plan. The process also includes the development of future goals and indication of preferred lifestyle choices, which are identified and included in the Person-Centered Support Plan, which is developed by a participant's Targeted Case Manager (TCM) in conjunction with the participant and their support team, including the individual's MCO.

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):

All applicants for program services must undergo an assessment to determine functional eligibility for the program. The Functional Eligibility Instrument (FEI) is utilized to determine the Level of Care eligibility for the HCBS program.

The state's eligibility contractor conducts the assessment of the applicant within five (5) working days of the completion of the program eligibility process, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate.

Participants are informed of services options available through the program by the MCO during the process of plan of care development. The participant will indicate his/her choice to receive home and community-based services on the Participant Choice Form of the Service Plan.

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. During the Service Plan development, the MCO will complete a needs assessment for the participant that will identify the necessary services to meet the needs of the participant.

The Service Plan (SP) is developed during a face-to-face meeting with the participant, guardian (if applicable), the IDD targeted case manager, the MCO and any selected representatives that the participant chooses to be involved.

The location of the meeting is normally in the participant's home, but arrangements can be made for another location if the participant desires. Date and time is always coordinated based on the convenience of the participant and the participant's representative, if applicable.

The initial SP must be developed within seven (7) working days of financial eligibility determination and must include the MCO informing the participant of all available service options and providers for whom the participant can access.

The development of the SP is finalized upon participant review and signed authorization. A copy of the SP developed during the face-to-face meeting will be provided to the participant at the time of the meeting. The participant must sign an acknowledgement that the MCO has informed him/her of all service options and available providers of those services.

Services provided are based upon the needs of the participant identified through the needs assessment and clearly documented on the participant's SP. The in-person health plan, needs assessment, and service plan must be completed to allow the participant to begin receiving services within fourteen (14) working days of financial eligibility determination.

The MCO must have a face-to-face meeting with the participant, legal guardian (if participant has one), and any selected representatives every six (6) months. During this face-to-face meeting, the SP will be reviewed and updated in accordance with the participant's current needs. Any change to services needs requires a new SP be completed. A participant requesting a change of provider must inform MCO and allow thirty (30) days for the transition unless an extenuating circumstance exists(i.e. ANE). The SP will be updated in accordance with the participant's change in provider. For each service change, the SP must be signed and dated or resigned and dated by both the MCO and the participant or participant's legal representative, and the updated copy must be provided within the timeframes specified in contract.

A participant's SP is developed based on the information gathered from the following:
•Current Functional Eligibility Assessment
•Needs Assessment
•Health Assessment, if applicable

The participant's SP takes into account information gathered from the current Functional Eligibility Instrument, which identifies potential risk factors. The SP will document the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service (including informal services and providers).

With the participant's approval, family participants or other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development and implementation of the SP. If the participant has a court appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures and dates documented on SP. The participant's desired outcomes and preferences are discussed when determining the services to be included in the SP.

It is the expectation that program participants who need assistance with daily living (ADL) or independent activities of daily living (IADL) tasks and who live with persons capable of performing these tasks, should rely on these informal/natural supports for this assistance unless there are extenuating or specific circumstances that have been documented in the service plan. The participant's available natural/informal supports and services provided by the natural supports must be clearly reported on the needs assessment and SP.

The MCO completes the appropriate forms indicating service tasks necessary to enable the participant to live safely in the most integrated environment possible. A physician's statement may be required if there is any question about cognitive impairments. A participant who is cognitively impaired may have difficulty self-directing as he/she may have difficulty communicating his/her needs and wants. A physician's statement is required if the participant elects to self-direct attendant care and requires health maintenance tasks or medication set-up.

The MCO must inform the providers the rate of services and discuss the hours of care to be delivered to the participant.

The MCO shall record all pertinent information received verbally or in writing from the participant, staff or collateral contacts in the case log. The MCO shall send the SP, the identified service tasks to be performed indicated from the needs assessment, and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated durable power of attorney, guardian, and conservator within contractual timeframes.

The MCO provides follow-up visits with the participant. The participant or their representative is required to report any changes that occur generating updates as needed to adjust services. The participant is involved in the development of the needs assessment regarding specific ADLs and IADLs associated with identified care needs and preferences. MCO coordinates other federal and state program resources in the development of the Service Plan.

The State of Kansas will ensure that the participant's settings meet the requirements for compliance with the HCBS Final Setting Rule, including integration in the greater community.

The Managed Care Organization will be responsible for assuring the following elements are included in the person-centered service plan:
*Reflect the setting in which the individual resides is chosen by the individual Includes the individual's strengths and preferences
*Be understandable to the individual receiving services and supports and the individuals important in supporting him/her
*Prevent the provision of unnecessary or inappropriate services and supports
*Document the positive interventions and supports including less intrusive methods
*Ongoing data measuring the effectiveness of modifications
*Assurance that interventions and supports will not cause harm.

The State will ensure that the setting chosen by the individual is integrated in and supports full access of participants receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

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.

K.A.R. 30-63-21 requires the provider, as part of its development of the person-centered support plan, to assist the participant or the participant's guardian to understand the negative consequences of choices the provider knows the participant might make and that may involve risk to that person. Any behavior intervention plan must follow regulatory language (K.A.R. 30-63-23) in order to ensure that all other potentially effective, less restrictive alternatives have been tried and shown to be ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective.

Further, the plan shall describe when it is necessary to do so, how the preferred lifestyle might be limited because of imminent significant danger to the participant's health, safety, or welfare based on as assessment of the following;
*The person‘s history of decision-making, including any previous experience or practice the participant has in exercising autonomy, and the participants‘ ability to learn from the natural negative consequences of poor decision-making;
*The possible long and short-term consequences that might result to the participant if the participant makes a poor decision;
*The possible long and short-term effects that might result to the participant if the provider limits or prohibits the participant from making a choice; and
*The safeguards available to protect the participant‘s safety and rights in each context of choices. As a part of the person-centered planning process, each provider of services for a participant shall discuss, and incorporate into the person-centered plan, any identified risks associated with leaving a participant unsupervised.

Appropriate times for supervision shall be identified and the provider will include its strategies to assure participants are not placed at risk when/ backup strategies need to be implemented. Providers of licensed services such as Residential Supports and Day
Supports are required in their policies and procedures to have the necessary backup plans in place such as emergency and disaster plans to assure the participants health and welfare.

In addition, these providers must have plans to assure necessary back-up staff is available in the event that scheduled staff cannot make it to work. For those who self-direct their services, a backup plan that is developed and monitored by the case manager must be in place to assure the participant receives the necessary supports to assure his/her health and welfare. This plan may include both the use of paid and natural supports. The service plan by the MCO must also include a back-up plan.

All parts of the person-centered support plan and service plan shall meet criteria outlined in the Intellectual and Developmental Disability Service Plan policy.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Developmental Disabilities Reform Act (DDRA) of 1995 specifies in section 39-1805 the duties of a Community Developmental Disability Organization (CDDO) to provide either directly or by subcontract, services to persons with a developmental disability including, among other things, an explanation to the participant of the available services and service providers in the CDDO area.

The CDDO, per K.A.R. 30-64-23, acts as the single point of application, determination, and referral for impartial information regarding the types and availability of community services within the service area and of the licensed providers and other agencies existing within the service area.

Participants receiving services will be advised of the available community service providers in the CDDO area on at least an annual basis and also when requested by the participant. This may be done in a variety of ways including lists which are updated on a regular basis or through the CDDOs website. Options counseling is documented by the CDDO and kept on file.

Once a participant is made aware of the services available and the providers of services in the area, the participant's case manager will assist him/her in meeting with and touring services provided. It becomes the case manager's role to facilitate, the participant and the participant's guardian if one has been appointed, through a process that ends with the participant choosing a provider of services that can meet the participant's support needs.

KDADS will provide a provider capacity map by CDDO catchment area that demonstrates access to services and provider capacity to meet identified needs. If a need for additional capacity is identified, the CDDO will provide a capacity development plan and work with the MCO to provide incentives to attract new providers as necessary.

If needed, the MCO will provide alternate temporary services while that capacity is developed.

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 individual's targeted case manager (TCM) develops a person-centered support plan and behavior support plan and submits it to the care coordinator (MCO case manager also referred to as a service coordinator) for review and inclusion in the Service Plan, which includes a service plan for HCBS waiver supports and services, behavioral health services, and physical health services. This activity is in accordance with the Intellectual and Developmental Disability Service Plan policy.

The MCO authorizes the Service Plan, and then it is shared electronically with the CDDO, TCM, and providers so that authorized services can begin. The Medicaid Agency has oversight responsibility of this process. A hard copy is provided to the participant and the participant's responsible party (if participant has a responsible party).

The Medicaid Agency monitors the following through a review of data provided by KDADS that is obtained through the Quality Management Strategy:
-Access to services
-Freedom of choice
-Participants needs being met
-Safeguards that are in place to assure that the health and welfare of the participant are maintained
-Access to non-waiver services, including state plan services and informal supports
-Follow-up and remediation of identified programs

A critical component of that strategy is the engagement of interagency monitoring, which will meet quarterly and bring together leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services.

KDADS meets on a monthly basis with the Medicaid Agency to discuss the waiver, including proposed policies and waiver amendments. On a quarterly basis, at the monthly meeting, the data obtained through the quality review process is presented to the Medicaid Agency. A portion of the data collected is obtained through a review of service plans to determine if the plan is meeting the needs of the participant while meeting the health and welfare needs of the individual. At the monthly meetings, any issues that may have been identified during the monitoring process are reported to the Medicaid Agency. Steps taken to resolve issues are also presented at that time.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

☒ **Other**

Specify:

Service plans and related documentation will be maintained by the participant's chosen KanCare MCO, local Community Developmental Disability Organization and the persons' Community Service Providers and will be retained at least as long as this requirement specifies, as well as per policy and contract.

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 SSMA and operating agency has overall responsibility for monitoring the service plans.

The SSMA has delegated direct monitoring of service plans to the MCOs to oversee provisions related to the services furnished in accordance with the service plan, participants' access to waiver services as identified in the service plan, participants' ability to choose a provider of choice, services meet participants' identified needs, effectiveness of back-up plans, participant health and welfare, participants' access to non-waiver services in service plan, including health services.

The three KanCare contracting managed care organizations are responsible for monitoring the implementation of the Service Plan that was developed as a partnership between the participant, participant's responsible party (if participant has responsible party),TCM, participant's team, and the MCO.

The three KanCare contracting MCOs are also responsible for ensuring the health and welfare of the participant with input from the IDD 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 Service Plan and participant needs to ensure:

•Services are delivered according to the Service Plan;
•Participants have access to the waiver services indicated on the Service Plan;
•Participants have free choice of providers and whether or not to self-direct their services;
•Services meet participants' needs;
•Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective; Participant's health and safety are assured, to the extent possible; and participants have access to non-waiver services that include health services.

The Service Plan is the fundamental tool by which the State will ensure the health and welfare of participants served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated service plans, their content and completion.

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 participant.
•Choice is documented in writing.
•The Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually, and authenticated by all necessary signatures and dates.
In addition, the 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 IDD 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 state interagency monitoring, 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 and the operating protocols of interagency monitoring which includes KDHE.

The CDDOs also assist the participant in identifying service providers in their region who may provide the type of service the participant is seeking.

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:*

Established safeguards include informal on-going review processes in place and conducted by KDADS Regional Field Staff, and more formal review through the National Core Indicators (NCI) survey.

The CDDOs also have a regulatory role for quality enhancement and quality assurance (K.A.R. 30-64-26 and K.A.R. 30-64-27, respectively).

The primary responsibilities for service plan monitoring lies with the KanCare MCOs and the participant's targeted case manager who are both prohibited from providing any direct service to the participant.

The Targeted Case Manager has a regulatory duty for monitoring and follow-up to ensure that the person-centered support plan and related supports and services are effectively implemented and adequately addressing the needs of the person (K.A.R. 30-63-32).

In addition, the safeguards in place for all other Medicaid providers apply to all Medicaid-enrolled Financial Management (FMS) agencies.

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 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	X **Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify:	X **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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify:	**Annually**	X **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:

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 (or their representatives) who were present and involved in the development of their service plan N = Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval =

		95 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:

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 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 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**

X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify:	X **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 service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify:	**Annually**	X **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:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of survey respondents who reported receiving all services as specified in their service plan N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
Other Specify:	**Annually**	X **Stratified** Describe Group: Proportionate by MCO
	Continuously and Ongoing	**Other** Specify:

	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews and Electronic Visit Verification (EVV)Reports

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

collection/generation *(check each that applies):*	*(check each that applies):*	
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify:	X **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:

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 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	X Quarterly	X Representative Sample Confidence Interval = 95%
X Other Specify: KanCare Managed Care Organizations (MCOs)	Annually	X 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):*
X State Medicaid Agency	Weekly
X Operating Agency	Monthly
Sub-State Entity	X Quarterly
X Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	X 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 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determinded by the State Operating Agency	X **Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation

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

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
X **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	X **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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%

X **Other** Specify: KanCare Managed Care Organizations	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State Operating Agency	X **Annually**
	Continuously and Ongoing
	Other Specify:

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

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, 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. MCO staff from 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 state interagency monitoring, 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 and the operating protocols of interagency monitoring.
Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

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

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

a)Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about services provided by direct service workers, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self- direct services:

•the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
•related responsibilities (outlined in E-1-a);
•potential liabilities related to the non-fulfillment of responsibilities in self-direction;
•supports provided by the managed care organization (MCO) they have selected;
•the requirements of direct service workers;
•the ability of the participant to choose not to self-direct services at any time; and
•other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency-directed services.
b)The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chose this option and identified an enrolled provider.

This information is also available from the IDD Program Manager and KDADS Regional Field Staff.

c)Information regarding self-directed services is initially provided by the MCO during the service plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's service plan. This information is reviewed at least annually with the member. The option to end self-direction can be discussed, and the decision to choose agency-directed services can be made at any time.

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 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.This Memorandum outlines the process for appointing a non-legal, designated representative.

At any time the Person-Centered Service Plan is being reviewed and updated, the performance of the non-legal 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 (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

The MCO may, if appropriate, discontinue the participant's choice to direct their services when, in the MCO's 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 based on the premise that one or more of 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 direct service worker is not providing the services as outlined in the authorized service plan, 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.;
•The participant chooses to employ a provider or maintain employment of a provider whose background check does not clear the list of Kansas prohibited offenses.

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 qualified 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.

When a participant is removed from self-direction they will be moved to agency-directed while receiving the same services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a)Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about services provided by direct service workers, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self-direct services:
•the services covered and limitations;
•the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
•related responsibilities (outlined in E-1-a);
•potential liabilities related to the non-fulfillment of responsibilities in self-direction;
•supports provided by the managed care organization (MCO) they have selected;
•the requirements of direct service workers;
•the ability of the participant to choose not to self-direct services at any time; and
•other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency- directed services.

b)The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chosen this option and identified an enrolled provider. This information is also available from the IDD Program Manager, KDADS Regional Field Staff, and is also available through waiver policies and procedure manuals.

c)Information regarding self-directed services is initially provided by the MCO during the service plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's service
plan. This information is reviewed at least annually with the member. The option to end self-direction can be discussed, and the decision to choose agency-directed services can be made at any time.

Information regarding participant direction of services is shared with each person at least annually during the eligibility redetermination (with the CDDO), and person-centered planning meetings.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- **The State does not provide for the direction of waiver services by a representative.**
- **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☒ **Waiver services may be directed by a legal representative of the participant.**
- ☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant.

The designation of a representative must comport with The Conflict of Interest Memorandum.This Memorandum outlines the process for appointing a non-legal, designated representative.

This includes situations when the representative has an activated durable power of attorney (DPA). The DPA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves.

A DPA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services.

Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid direct service worker for Personal Care Services and/or Enhanced Care Services.

Safeguards include:

•If the designation of the appointed representative is withdrawn, the individual may become the participant's paid direct service worker for Personal Care Services and/or Enhanced Care Services after the next annual review or a significant change in the participant's needs occurs prompting a reassessment.

•A participant who has been adjudicated as needing a guardian and/or conservator cannot choose care. The participant's guardian and/or conservator may choose to self-direct the participant's care. An adult waiver participant's legal guardian and/or conservator cannot, however, act as the participant's paid attendant direct service worker for Personal Care Services and/or Enhanced Care Services and/or Overnight Respite.

To ensure that non-legal representatives function in the best interests of the participant, additional safeguards are in
place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self-direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the participant's case file, certain situations arise, particularly when the participant's health and welfare needs are not being met.

In addition, post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS Regional Field Staff and/or MCO staff serve to monitor participant services, and serve as safeguards to ensure the participant's best interests are followed.

Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Representatives who are self-directing services for a participant may not also be the paid caregiver/provider of HCBS services for the participant. If the representative chooses to be the paid caregiver, another representative must be selected to direct the participant's care.
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.

At any time, the Person-Centered Service Plan is being reviewed and updated, the performance of the non-legal 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
Overnight Respite Care	X	
Financial Management Services (FMS)	X	
Personal Care Service	X	
Enhanced Care Service	X	

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

  X **Private entities**

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- **FMS are covered as the waiver service specified in Appendix C-1/C-3**

  The waiver service entitled:

  Financial Management Services

  FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

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

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

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license / certification if required and adherence to KDADS' training and professional development requirements. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

In addition, organizations are required to submit the following documents with the signed agreement:

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:
•Community Developmental Disability Organization (CDDO) affiliate agreement (IDD 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.
•Including process for conducting background checks
•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 prior to signing by the Secretary of KDADS (or designee).

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

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a) The state 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).

Requirements include agreements between the FMS provider and the participant, Direct Service Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Service 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 Service Worker satisfaction; maintain a grievance process for Direct Service 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 the 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. The Kansas Department of Health and Environment 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)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
Medical Alert Rental	
Overnight Respite Care	
Financial Management Services (FMS)	
Residential Supports	
Supported Employment	
Specialized Medical Care	
Personal Care Service	
Assistive Services	
Enhanced Care Service	
Wellness Monitoring	
Day Supports	

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:

The Department for Aging and Disabilities Services contracts with the Self-Advocate Coalition of Kansas (SACK) to provide training to participants regarding the self-directed option for service delivery. Each person is given contact information for SACK upon request.

The Disability Rights Center (DRC) is another agency that can assist participants on the waiver to access advocacy. The Disability Rights Center of Kansas (DRC), is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities.

Kansas Centers for Independent Living (CILs) also offer advocacy assistance for people with disabilities as one of their five core services that are grant funded.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

One of the participant's opportunities as well as responsibilities is the ability to discontinue the self-direct option. If the participant chooses to discontinue the self-direct option, he/she is to;
*Notify all providers as well as the Financial Management Services (FMS) entity. The participant is to maintain continuous PCS, ECS and/or Overnight Respite coverage, whichever service was previously documented on the participant's Service Plan, with the authorization for service;
*Give a thirty (30) day notice of their decision to the Community Developmental Disability Organization (CDDO), the targeted case manager, and the MCO to allow for the coordination of service provision.

The duties of CDDO staff are to:
*Present the participant with the other service options and the providers of those services in the CDDO area, completing a choice form.

The duties of the consumer's case manager and the KanCare MCO in collaboration, are to:
•Explore other service options and receive a copy of the completed new Choice form from the CDDO; and
•Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources.

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 participant's choice to direct their services when, in the MCO's 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 based on the determination that one or more of 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 direct service worker is not providing the services as outlined in the authorized Service Plan, 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.;
•The participant chooses to employ a provider or maintain employment of a provider whose background check does not clear the list of Kansas prohibited offenses.

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 all qualified agency-directed services as an alternative.

If the participant chooses an alternative agency-directed service, 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	2656	
Year 2	2756	
Year 3	2270	
Year 4	2270	
Year 5	2270	

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:

[ ]

[X] **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*:

[X] **Recruit staff**

Refer staff to agency for hiring (co-employer)

[X] **Select staff from worker registry**

[X] **Hire staff common law employer**

[X] **Verify staff qualifications**

[X] **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.

[X] **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.**

[X] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

[X] **Determine staff wages and benefits subject to State limits**

[X] **Schedule staff**

[X] **Orient and instruct staff in duties**

[X] **Supervise staff**

[X] **Evaluate staff performance**

[X] **Verify time worked by staff and approve time sheets**

[X] **Discharge staff (common law employer)**

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

Reallocate funds among services included in the budget

Determine the amount paid for services within the State's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Kansas has contracted with CDDOs to conduct level of care determinations. Decisions made by the CDDOs are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors as part of the assessment Tier notification process.

Upon completion of the functional eligibility determination, the CDDO assessor shall initial and date the notice of action for the assessment tier and mail a copy of the notice to the person and/or the person's responsible party. A copy will be sent the same day to the TCM for the person, and to all HCBS providers.

Level of care appeals are limited to tier 0 assessments, as an adverse action to the participant, as a tier 0 indicates that the participant is functionally ineligible and is therefore not eligible for waiver services or to be added to the IDD waiver waitlist. Tiers between 1-5 do not create an adverse action for the participant, and therefore cannot be appealed.

Kansas has contracted with three 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, about which they must inform every member. In addition, the State will review member grievances/appeals during the initial implementation of the KanCare program on a daily basis to see if there are issues with getting into care, ability to get prescriptions or ability to reach a live person on the phone. The State will report to CMS upon request the number and frequency of these types of complaints/grievances during the initial transition period and will continue to monitor this issue throughout the KanCare program.

Each participant is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. Participant grievance process and Fair Hearing process can also be found at the KanCare website.

KanCare participants have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 calendar days of receipt, and a written response to the grievance will be given to the participant within 30 calendar days (except in cases where it is in the best interest of the member that the resolution timeframe be extended).
If the MCO fails to send a grievance notice within the required timeframe, the participant is deemed to have exhausted the MCO's appeal process, and the participant may initiate a State Fair Hearing.

An appeal can only occur under the following circumstances:
•If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service that the participant has 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.
•The Participant 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: The Participant, Participant's friend, participant's attorney, or anyone else on the participant'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 the participant's health plan can also help the participant with an appeal.
•An appeal must be filed within 60 calendar days plus 3 calendar days after the participant has received a Notice of Action.
•The appeal will be resolved within 30 calendar days unless more time is needed. You The participant will be notified of the delay, but your the participant’s appeal will be resolved
in 45 calendar days.

If the participant is on the IDD waiver, previously authorized IDD waiver services must continue during the appeal period timeframe (63 continuous days), in order to ensure that continuity of care is provided while the appeal period is in effect and to provide the participant time to appeal.

Fair Hearings
A Fair Hearing is a formal process where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all of the facts and then hears motions, conducts hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge.

•If the participant is not satisfied with the decision made on
his or her appeal, the participant or participant's 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
•The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision.

Participants have the right to benefits continuation of previously authorized IDD waiver services while a hearing is pending and can request such benefits as part of their fair hearing request. All three MCOs will advise participants of their right to a State Fair Hearing. Participants have to finish their appeal with the MCO before requesting a State Fair Hearing.

For all KanCare MCOs:
In addition to the education provided by the State, participants receive information about the Fair Hearing process in the participant handbook they receive at the time of enrollment. The participant handbook is included in the welcome packet provided to each person. It will also be posted online at the MCOs' participant 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 participant can call the MCO to get information and assistance with the Fair Hearing process.

The state requires that all MCOs define an "action" pursuant to 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.

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.

All disputes (excluding those related to eligibility or across the board funding cuts implemented pursuant to the KDADS/CDDO Contract) shall follow the local dispute resolution process. If a participant chooses to use the local dispute process, they are informed that the local process is not a pre-requisite or a substitute for a Fair Hearing, and by using the local process, that process in no way impedes a person's opportunity to request a Fair Hearing.

Pursuant to K.A.R. 30-64-32, the role of KDADS is to provide a summary review of the decision made by the CDDO Governing Board (or other designated board). KDADS reviews these decisions to ensure applicable policies, practices and procedures are followed at the local level.

If they have not been correctly implemented, the review process provides KDADS an opportunity to instruct the CDDO to make a corrective action. This process ensures the appropriateness of local decisions to avoid having parties unnecessarily request a Fair Hearing.

However, participants are informed that this process is not a pre-requisite for a fairing hearing or in any way prohibits the participant from pursuing a fair hearing.

If KDADS confirms the local decision, the party to the dispute will then be referred to the Office of Administrative Hearings (OAH). A copy of K.A.R. 30-64-32 and a copy of the policy regarding K.A.R. 30-64-32 review is available to CMS upon request.

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:

The Medicaid agency employs the fiscal agent, DXC, to operate the consumer complaint and grievance 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.

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. The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time.

Participants who are not part of the KanCare program are part of the State's fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State's fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for- service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. KDADS and KDHE have access to this information at any time.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time.

Participants who are not part of the KanCare program are part of the State's fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State's fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for- service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager, or by the Ombudsman's office.

As part of its regulatory role to educate consumers regarding their rights and responsibilities, CDDOs educate consumers regarding their due process rights including the complaint/grievance process and the fair hearing process. DDRA and implementing regulations available to submit to CMS upon request.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

No. This Appendix does not apply *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Definitions of Kansas Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 39, Article 14 for adults, and Kansas Statute Chapter 38, Article 22 for children:

K.S.A. 39-1430. Abuse, Neglect or Exploitation of certain adults:

K.S.A. 39-1430(b):
Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a waiver participant, including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult; 4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5) a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6) Fiduciary Abuse; or 7) omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

K.S.A. 39-1430(c):
Neglect: The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

K.S.A. 39-1430(d):
Exploitation: Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

K.S.A. 39-1430(e):
Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit.

Department for Children and Families (DCF) reportable events as described in Kansas Statute:

•Neglect - K.S.A. 38-2202(t): Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include, but shall not be limited to:
(1) Failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child;
(2) failure to provide adequate supervision of a child or to remove a child from a situation which requires judgment or actions beyond the child's level of maturity, physical condition or mental abilities and that results in bodily injury or a likelihood of harm to the child; or
(3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent; however, this exception shall not preclude a court from entering an order pursuant to K.S.A. 2018 Supp. 38-2217(a)(2), and amendments thereto.
•Physical, Mental or Emotional Abuse - K.S.A. 38-2202(y): The infliction of physical, mental or emotional harm or the causing of a deterioration of a child and may include, but shall not be limited to, maltreatment or exploiting a child to the extent that the child's health or emotional well-being is endangered
•Sexual Abuse - K.S.A. 38-2202(ff): Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child or another person. Sexual abuse shall include, but is not limited to,

allowing, permitting or encouraging a child to:
(1) Be photographed, filmed or depicted in pornographic material; or
(2) be subjected to aggravated human trafficking, as defined in K.S.A. 2018 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another, or be subjected to an act which would constitute conduct proscribed by article 55 of chapter 21 of the Kansas Statutes Annotated or K.S.A. 2018 Supp. 21-6419 or 21-6422, and amendments thereto.
•Abandonment - K.S.A 38-2202 (a): To forsake, desert or, without making appropriate provision for the substitute care, cease providing care for the child.
•Fiduciary Abuse - K.S.A. 39-1430(e): A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit

All DCF reportable events including Abuse, Neglect, Exploitation, and Fiduciary Abuse are required to be reported to the Kansas Department for Children and Families and once a determination has been made by DCF, the event must be entered into the Adverse Incident Reporting (AIR) system by KDADS if the event has not yet been entered by DCF staff in accordance with KDADS HCBS Adverse Incident Monitoring Standard Operating Procedure (SOP).

Reporting KDADS defined adverse incident requirements:

Other adverse incidents to be reported by KDADS staff into AIRS include, Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt. See KDADS HCBS Adverse Incident Reporting and Management Policy 2017-110 for definitions of all adverse incidents that are required to be reported by KDADS staff.

Additionally, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. These acts include all use of restraints, seclusion and restrictive intervention.

•Identification of the individuals/entities that must report critical events and incidents:
The Kansas statutes K.S.A. 39-1431 and K.S.A. 38-2223 identify mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult or minor immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Specifically, mandated reporters include: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC),

Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF), Substance Abuse Treatment Facilities and Targeted Case Managers (TCM).

All other individuals who may witness a reportable event may voluntarily report it.

•The timeframes within which critical incidents must be reported:

All reports of suspected Abuse, Neglect, Exploitation, and Fiduciary Abuse must be reported to the Kansas Department for Children and Families
promptly and in accordance with K.S.A. 39-1431 for adults and K.S.A. 38-2223 for children. All other adverse incidents as defined by KDADS in this section and as defined in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 must be reported directly into the AIR system no later than 24 hours of becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110.
•The method of reporting:

Reports shall be made to the Kansas Department for Children and Families during the normal working week days and hours of operation. Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330 or online at http://www.dcf.ks.gov/Pages/Report-Abuse-or-Neglect.aspx. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911. All reports directed to DCF will be uploaded into the web-based Adverse Incident Reporting system (AIR).

Kansas Department for Children and Families reportable incidents and all KDADS defined adverse incidents must be reported directly into AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP. These include, in addition to suspected incidents of Abuse, Neglect, Exploitation or Fiduciary Abuse: Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Restraint, Seclusion, E/R visit, Hospitalization, Misuse of Medications, Natural Disaster, Serious Injury, Suicide, Suicide Attempt. See KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 for definitions of KDADS reportable adverse incidents. Also, the reporter can select as many adverse incidents as may apply per that particular situation. Anyone who suspects a child or adult is experiencing any of the above types of DCF reportable events or KDADS adverse incidents may also report it through the DCF hotline.

Definitions of Kansas Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 39, Article 14:

K.S.A. 39-1430. Abuse, Neglect or Exploitation of certain adults; definitions:

K.S.A. 39-1430(b):
Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a waiver participant, including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult; 4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5) a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6) Fiduciary Abuse; or 7) omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

K.S.A. 39-1430(c):
Neglect: The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or

services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

K.S.A. 39-1430(d):
Exploitation: Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

K.S.A. 39-1430(e):
Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit.

All DCF reportable events including Abuse, Neglect, Exploitation, and Fiduciary Abuse are required to be reported to the Kansas Department for Children and Families and once a determination has been made by DCF, the event must be entered into the Adverse Incident Reporting (AIR) system by KDADS if the event has not yet been entered by DCF staff in accordance with KDADS HCBS Adverse Incident Monitoring Standard Operating Procedure (SOP).

KDADS defined adverse incident reporting requirements:

Other adverse incidents to be reported by KDADS staff into AIRS include, Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt. See KDADS Policy 2017-110 for definitions of all adverse incidents that are required to be reported by KDADS staff.

Additionally, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. These acts include all use of restraints, seclusion and restrictive intervention.

•Identification of the individuals/entities that must report critical events and incidents:
The Kansas statutes K.S.A. 39-1431 identifies mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult immediately to either Kansas Department for Children and Families or Law Enforcement. According to
K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Specifically, mandated reporters include: Staff working for any KDADS licensed or contacted organization, including

Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF), Substance Abuse Treatment Facilities and Targeted Case Managers (TCM).

All other individuals who may witness a reportable event may voluntarily report it.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, andwebsite and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development.

Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant’s Person-Centered Service Plan. The information provided by the MCOs is consistent with the state’s Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

CDDOs have a regulatory role for educating on, reporting of, and correcting events of Abuse, Neglect and Exploitation, as per K.A.R. 30-64-27.
IDD waiver providers also have a regulatory responsibility for education on, reporting, and correcting abuse, neglect and exploitation, as per K.A.R. 30-63-28.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

•The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per
K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.

The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of becoming aware of the adverse incident by direct entry into the KDADS web- based AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP.

•The entity that is responsible for evaluating reports and how reports are evaluated:

All reports of Abuse, Neglect, Exploitation and Fiduciary Abuse are reported to and investigated by DCF. Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with, K.S.A. 38-2223 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS, which is entered into AIRS and reviewed by KDADS staff.

KDADS is the entity responsible for evaluating all adverse incident reports in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS HCBS Adverse Incident Monitoring SOP. All events reported to AIRS are reviewed by KDADS staff to determine whether or not they meet the SOP definition of an adverse incident. Those that do not are screened out from further investigation by KDADS. Those that meet the definition are investigated by KDADS and contracted MCOs. Any event reported through AIRS that involves the possible abuse, neglect, exploitation or fiduciary abuse of children that was not reported first to DCF is immediately reported to DCF by KDADS for further investigation.

In accordance with the KDADS HCBS Adverse Incidents Monitoring Standard Operating Procedure (SOP), KDADS Program Integrity and Compliance Specialists (PICS) or their designated back-up(s) are responsible for checking AIRS for any newly reported adverse incident. AIRS will automatically distribute adverse incident reports for review based on the issue, KDADS provider/program type (e.g., Behavioral Health, Older Americans Act, Senior Care Act, HCBS Waiver), and county location of the incident. If data was entered incorrectly, the KDADS PICS must correct any errors, and re-route the review to the appropriate KDADS party. This process will occur within one business day of receipt of an adverse incident report.

If AIRS does not auto assign the adverse incident, the KDADS PICS will review the adverse incident report and assign it appropriately within AIR. If the member requires protective services intervention or review, the PICS will immediately notify and forward the adverse incident report to (DCF) for further investigation.

If an Adverse Incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in each of the HCBS waivers. DCF must notify KDADS outlining DCF's determination for the incident within five business days of the date of DCF determination, in accordance with the DCF Policy and Procedure Manual (Chapter 10320) and as defined in KSA 39- 1433/38-2226.

For all submitted AIR reports, PICS first review AIRS adverse incident report information to determine if there is any indication of criminal activity and report any instances to law enforcement. If it is determined that there is suspected for Abuse, Neglect, Exploitation or Fiduciary Abuse, the KDADS PICS report immediately to DCF. Any areas of vulnerability would be identified for Additional training and assurance of education. PICS determine if the adverse incident report is screened in, screened out, or requires additional follow-up. Even for those incidents referred to DCF, PICS document the incident and notify the participant's MCO of the incident.

Within one business day of receiving an AIR report, KDADS PICS will determine the level of severity for each screened in adverse incident reported in AIRS and will assign a level of severity. Within one business day of a determination of the severity level PICS will notify the participant's MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS.

KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member's Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP.

All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up. KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member's Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP.

•The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. Per PPS policy number 1521, reports assigned for Abuse/Neglect concerns shall be assigned with either a same day or 72-hour response time. Reports assigned as Non-Abuse/Neglect Family in Need of Assessment (NAN FINA) are assigned a response time per PPS policy number 1670.
PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. KDADS assigns the report to the participant's managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

•The entity that is responsible for conducting investigations and how investigations are conducted:

DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

Review and Follow-up for Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with
K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children.

1.DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF, if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services.
2.DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS.
3.The report will not be assigned for further assessment or may be screened out after acceptance if the following apply:
a.The report does not meet the criteria for further assessment per DCF PPS Policy and Procedure Manual;
b.The event has previously been investigated;
c.DCF does not have the statutory authority to investigate;
d.Unable to locate family.
4.Not all reportable events require remediation; DCF shall determine which reportable events will result in remediation.

The process and timeframes for informing the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results includes:

Notice of Department Finding per DCF PPS Policy Number 2540:
The Notice of Department Finding for reports is PPS 2012. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.

All case decisions/findings shall be staffed with the CPS Supervisor/designee and a finding shall be made within thirty (30) working days of receiving the report. DCF sends the Notice of Department Finding to relevant persons who have a need to know of the outcome of an investigation of child abuse/neglect on the same day, or the next business day, of the case finding decision.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Kansas Department for Children and Families (DCF) is responsible for overseeing the reporting of and response to all reportable events related to Abuse, Neglect, Exploitation and Fiduciary Abuse. DCF maintains a database of all reportable events and transfers pertinent information from the database to AIRS.

KDADS is the entity responsible for overseeing the operation of the web-based adverse incident management system called AIRS and responding to incidents reported in AIRS.

•The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

The KDADS Program Integrity Manager will, on a monthly basis, provide an AIR System Reconciliation Report to DCF-APS and CPS, which includes the number of all incidents KDADS received from each entity in the reported month. The purpose of this report is to verify all incidents reported to DCF-APS and CPS that require KDADS review were subsequently provided to KDADS. KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

The KDADS Program Quality Management Specialists Program Manager will review statewide trend analysis from AIR system aggregate-level reports across all MCOs and determine how the overall number of adverse incidents compares to previous reports. For each MCO, and across all MCOs, the Program QMS Program Manager will determine if there is a pattern in the number and percentage of adverse incidents and the potential driving forces. Based on these trends, favorable outcomes will be promoted and trends with the potential to negatively impact the program or members will be remediated. KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

•The frequency of oversight activities:

In accordance with the KDADS HCBS Adverse Incident Monitoring SOP, KDADS PICS are responsible for monitoring AIRS on an ongoing basis and identifying adverse events that require follow-up investigation or remediation within one business day of receiving the report through AIRS. KDADS conducts reviews on a quarterly basis to determine that participants have received education from their MCO on their ability and freedom to prevent or report information about Abuse, Neglect, Exploitation or Fiduciary Abuse in accordance with KDADS HCBS Adverse Incident Reporting and Management Policy and KDADS Adverse Incident Monitoring SOP.

1.Each MCO shall submit a monthly electronic report to KDADS Program Integrity which captures the following:
a.Performance data on each health and welfare performance measure as identified in each HCBS waiver.
b.Trend analysis by each HCBS waiver health and welfare performance measure.
c.Trend analysis on each type of adverse incident as defined in the KDADS HCBS Adverse Incident Monitoring SOP.
d.Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
e.Remediation efforts by type of each adverse incident.

2.KDADS shall review MCO monthly reports containing performance data, trend analysis and remediation efforts, and shall conduct a random sampling of MCO (quarterly) records to determine the following:
a.Whether MCOs are taking adequate action to resolve and prevent adverse incidents.
b.How long it takes for an adverse incident to be resolved after becoming aware of an adverse incident or receipt of an adverse incident report.
c.Whether a Corrective Action Plan (CAP) is needed for the MCO to resolve identified deficiencies. Each CAP will be assigned a level of severity in accordance with KDADS Adverse Incident Monitoring Policy and KDADS Adverse Incident Monitoring SOP:
i.Level 1 – Deficiencies that are administrative in nature or related to reporting that have no direct impact on service delivery.

ii.Level 2 – Deficiencies that have the potential to impact the health, safety, or welfare of the member, or the ability to receive or retain services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

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

- **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).

•Identify the types of restraints permitted:

The IDD waiver allows for the authorized use of personal (physical holds), mechanical and chemical restraint. Under K.S.A. 39-1401 Abuse, Neglect or Exploitation of residents, the following are not permitted:

1.unreasonable use of physical restraint or medication that harms or is likely to harm a resident;
2.unreasonable use of a physical or chemical restraint or medication 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 resident or another resident.

•Alternative methods to avoid the use of restraints:

Participants served shall have the right to be free from the unauthorized, unsafe, or unwarranted use of restraint. Restraint is prohibited for the purposes of discipline, punishment or staff member convenience. The use of restraint is not a treatment intervention, and restraint is prohibited as an alternative to providing adequate levels of staff to manage the participant. A waiver participant and his/her designated legal representatives, guardians, and any informal supports or service providers requested by the participant, will participate in an annual (at a minimum) Person-Centered Service Plan (PCSP) meeting with the participant's MCO care coordinator to develop a Person-Centered Service Plan. The MCO care coordinator will ensure that the participant and his/her legal guardian and representatives develop strategies to address participant's preferences that put him/her at a health or safety risk. These strategies will only be to mitigate risks to the health and safety of the participant and other individuals whom might be harmed by a dangerous act by the participant. These strategies will include the use of positive behavioral supports, other less restrictive interventions, and a clear understanding will be conveyed that the use of restraint is a measure of last resort to protect the safety and health of the participant, his/her guardians, providers and informal supports. When situations arise that require behavioral intervention for a participant, methods of de-escalation, justification for authorized restraint use and the method of restraint applied must be documented by the involved staff.

All providers shall facilitate efforts to define alternative methods of behavior management to keep a potential safety situation from escalating to emergency status. These positive behavior supports may include, but are not limited to, restructuring the environment, reducing exposure to negative stimuli, positive redirection, changing instructions, providing visual supports to facilitate understanding.

To avoid use of restraints, KDADS reviews provider policies, procedures, training & documentation for evidence that all potentially effective less restrictive alternatives were tried & proven ineffective. KDADS conducts reviews to identify evidence of informed consent that includes information about positive behavior programming, environmental modifications and accommodations and services available from the provider. Informed consent must also include a complete review of the risks, benefits and side effects prior to any restraints and/or seclusion including psychotropic medications, and that the required initial and ongoing assessment and responsive modifications are completed.

•Methods for detecting the unauthorized use of restraints:

Each incident of restraint will be entered into AIRS for use in identifying unauthorized use of restraints. KDADS staff monitors each use of restraint and conducts analysis to determine unauthorized use and contacts the participant's Managed Care Organization (MCO) to discuss any potential unauthorized use. This information will be used by KDADS to identify and address any negative trends in the use of restraint if the situation warrants intervention and remediation. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized restraint/seclusion.

The MCO care coordinator will conduct a review within 30 calendar days of implementation of the PCSP to determine the effectiveness of defined interventions and to discuss if adjustments to the restrictive interventions plan should be made with the input of the participant's designated team members to include parent/legal guardian and care coordinator. A team meeting may be convened at any time to review and possibly make changes in the use of restrictive interventions, including restraint. Any plan developed by the team shall be signed by the participant's parent/legal guardian to document his/her approval. No plan shall be implemented without the participant's parent/legal guardian's consent. Following this initial review, on-going review of use of restrictive interventions, including restraint, will be part of the PSCP review annually or more often as deemed necessary by the designated team members.

•The protocols that must be followed when restraints are employed (including the circumstances when their use is permitted) and how their use is authorized:

Physical restraint techniques should only be used when all less restrictive methods of intervening have been exhausted and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Physical restraints are not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, positive behavior supports, constructive, non-physical de-escalation and re-structuring of the environment shall be considered prior to initiating a physical restraint, and all such use will be compliant with Article 63 – Developmental Disabilities – Licensing Providers of Community Services.

•The practices that must be employed to ensure the health and safety of individuals:

1.If a participant is known to have any medical condition such that restraint might endanger his/her health and safety, use of restraint is prohibited.
2.Restraint shall be administered only when needed to ensure the safety of the participant and/or other individuals in the immediate environment, (including staff members, other participants, other individuals) and only when needed to prevent the continuation or renewal of an emergency.
3.Restraint shall be administered only for the period of time necessary to accomplish its purpose and using no more force than is necessary, and prevention of harm to the participant will be the priority if a restraint is administered.

•Required documentation concerning the use of restraints:
1.When restraint is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the restraint, as follows:
2.Description of the antecedents (e.g. environmental conditions, activity, who was working with the participant, other individuals in the area) immediately preceding the use;
3.The specific behavior being addressed (e.g. number of occurrences, duration, description based on operational definition);
4.The alternative strategies used to de-escalate the situation prior to use (e.g. sensory stimulation, choices, redirect to preferred activity);
5.How the restraint ended, including physical, medical and behavioral status of the participant (e.g. injuries, medical care provided, 10 seconds of calm and discontinuation of restraint);
6.What happened after implementation of the restraint (e.g. participant demonstrated behavior again, participant left the room);
7.From on-set of behavior to discontinuation of the restraint, staff reflect on and document the PCSP strategies they would implement again, or they would use differently;
8.Notify care coordinator, as identified in the PCSP;
9.Notify parent/legal guardian, as identified in the PCSP.

•Education and training requirements that personnel who are involved in the administration of restraints must meet: All service providers implementing restraint must be properly trained and knowledgeable of the following:
1.Methods of safely escorting the participant;
2.Methods for safely implementing the restraint;
3.Supervision of the participant while in restraint;
4.Understanding of rules governing restraint practices;
5.Training is conducted within specific timelines of a nationally recognized, best practice training curriculum specific to restraint and should include, at a minimum:
a.Proper use of positive behavior supports, techniques and strategies designed to minimize and prevent the need for use of restraint, such as observing participant and staff behaviors, potentially distressing events, and environmental factors that may trigger emergency safety situations requiring the use of restraint; positive behavior supports includes the use of nonphysical intervention skills such as de-escalation, mediation and conflict resolution, active listening and other verbal and observational methods to detect and prevent emergency safety situations;
b.Safe administration of restraint;
c.Physical safety during emergencies;
d.Identification of the effects of restraint on the participant including physical signs of distress and need for medical attention;
e.Simulated experience of administering and receiving restraint;
f.Proof of appropriate training should be documented in provider staff's personnel file;
g.Methods to explain the use of restraint to parents or caregivers of the participant;
h.Documentation and notification procedures.
All training programs and materials used by the licensed waiver provider will be available for review by CMS, the State Medicaid Agency (KDHE), and KDADS. KDADS staff review training records & interview to ensure compliance with mandatory training. Staff must be able to demonstrate understanding & implementation of the training (including the PCSP standards).

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:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraint. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

•Methods for detecting use of seclusion and ensuring that all applicable state requirements are followed:
All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.
•How data are analyzed to identify trends and patterns and support improvement strategies: KDADS will monitor data within AIR to assess:
1.AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2.Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3.Trend analysis on each adverse incident.
4.Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5.Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

•The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed, site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

•The frequency of oversight:
Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1.Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2.Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3.Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

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:

- **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.

•The types of restrictive interventions that are permitted, the circumstances under which they are allowed, and the types of restrictive interventions that are not allowed:

Restrictive interventions are participant-specific and are what the participant and/or their team deems necessary, after other less-restrictive measures such as positive behavior supports have been tried to keep the participant and others around him/her safe. There is not a "listing" of what is permissible, however, a risk assessment is first necessary to determine the necessity of the restriction, a Behavior Management Plan (BMP) must be developed to provide a plan and oversight and then the plan must be reviewed by a Human Rights Committee (HRC) or also known as a Behavior Management Committee (BMC) to review the planned restriction. Some examples of restrictions may be locking food up for those with an eating disorder, or keeping sharps locked up, or one-on-one staff to be available to help de-escalate a situation or prevent aggressive behaviors to another individual, or self-harm.

•For each type of restrictive intervention that is permitted, the state's safeguards address: o First, use of non-aversive methods:

KDADS staff are responsible for ensuring compliance with regulated safeguards through initial approval and periodic review of agency policies and procedures. For each type of restrictive intervention, including physical and chemical, the following methods describe the use of alternative methods that are used to avoid use of restrictive interventions.

For any restriction of an individual's access to person, places or thing that put the individual's health, safety, or welfare at risk, the following should be addressed, in accordance with K.A.R. 30-63-21:

1.What is the person's history of decision-making?
2.What are the possible long and short-term consequences associated with poor decision making? (What is the worst that could happen?)
3.What are the possible long and short-term consequences of increased direction and control by staff or system?
4.Existence of safeguards to protect the person's rights.
5.Should more control and direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the consumer.

Review of this information is monitored by KDADS field staff.

Behavior Support Plans will be implemented in accordance with K.A.R. 30-63-23. Providers must take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions must be taken before the provider initiates the use of any medication or other restrictive intervention unless the needs of the person served clearly dictate otherwise and the provider documents that need. Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or other restrictive intervention to manage behavior or to treat diagnosed mental illness. Such proactive and remedial actions include safeguards (initial and
ongoing assessment and responsive modifications that may be needed), management (initial and ongoing assessment and responsive modifications that may be needed), and review by a behavior management committee established by the provider.

A Behavior Support Plan is monitored in accordance with the following standards and is included in the individual's Person-Centered Service Plan.

1.If any restrictive intervention or psychotropic medication being used for or by the person, the person and

support team have examined, determined and documented it to be the least restrictive intervention appropriate for this person.
2.If there is any restrictive intervention or psychotropic medication being used for or by the person, positive supports, accommodations and effective services have been considered, documented and are consistently present in the person's life.
3.If there is any restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the behavioral issue being addressed is clearly defined, together with a description of how it's frequency and severity will be measured, as well as a description of how often the support will be reviewed and what criteria will be used for the reduction or elimination (only when appropriate) of the intervention or medication.
4.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved and are consistently providing related positive behavioral supports.
5.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.
*Methods to detect unauthorized use of restrictive interventions:

Oversight to detect unauthorized use of restrictive interventions and compliance with regulatory standards and statute is conducted by the KDADS Regional Field Staff. On-going review includes interviews with the individual, informal supports and paid staff support and review of person-centered support planning. Additionally, the Community Developmental Disability Organization monitors for compliance with regulatory standards and statute to assure protection from unauthorized restrictive intervention.

As described further in Appendix G-1-b and G-1-d, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, the Money Follows the Person program, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-
110. These acts include all use of restraints, seclusion and restrictive intervention.

*Protocols for authorizing the use of restrictive interventions, including treatment planning requirements and review/reauthorization procedures:

For any restriction of an individual's access to person, places or thing that put the individual's health, safety, or welfare at risk, the following should be addressed, in accordance with K.A.R. 30-63-21:
1.What is the person's history of decision-making?
2.What are the possible long and short-term consequences associated with poor decision making? (What is the worst that could happen?)
3.What are the possible long and short-term consequences of increased direction and control by staff or system?
4.Existence of safeguards to protect the person's rights.
5.Should more control and direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the consumer.

Review of this information is monitored by KDADS field staff.

In addition, K.A.R. 30-63-23 requires that voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the

use of any restrictive interventions or medications.

Authorized restrictive interventions should only be used when all less restrictive methods of intervening have been exhausted and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Physical restraints are not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, positive behavior supports, constructive, non-physical de-escalation and re-structuring of the environment shall be considered prior to initiating a physical restraint, and all such use will be compliant with Article 63–Developmental Disabilities–Licensing Providers of Community Services.

*Required documentation when restrictive interventions are used:

The following must be documented in each participant's Person-Centered Support Plan in accordance with K.A.R. 30-63-21 implementation.
K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee.

1.A provider shall take proactive and remedial actions to ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness. These actions shall be taken before the provider initiates the use of any medication or other restrictive intervention to manage behavior unless the needs of the person served clearly dictate otherwise and the provider documents that need. Otherwise, these actions shall be taken promptly following the initiation of, or any change in, the use of any medication or other restrictive intervention to manage behavior or to treat diagnosed mental illness.
2.These proactive and remedial actions shall include all the following:
a.Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and document the following, in consultation with the person, the person's guardian, and the person's support network;
b.All other potentially effective, less restrictive alternatives have been tried and shown ineffective, or a determination using best professional clinical practice indicates that less restrictive alternatives would not likely be effective;
c.Positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person's life;
d.Voluntary, informed consent has been obtained from the person or the person's guardian if one has been appointed, after a review of the risks, benefits, and side effects, as to the use of any restrictive interventions or medications; and
e.Medications are administered only as prescribed, and no "PRN' (provided as needed) medications are utilized
without both the express consent of the person or the person's guardian if on has been appointed, and per usage approval from the prescribing physician or another health care professional designated by the person or the person's guardian if one has been appointed.

Additional required documentation:

The field staff monitors for documentation of the standards described above for the Behavior Support Plan in the Person-Centered Support Plan and reviews that evidence services and supports are provided in accordance with the Person-Centered Support Plan. In addition, to these standards, field staff also review the documentation for the following:

1.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by

the person, the provider is periodically reviewing and reporting to the person, support team and prescribing physician (when applicable), information about the frequency and severity of the behavioral issue involved, effectiveness of the intervention or medication being used, and any medication side effects.
2.A behavior management committee (meeting the membership criteria described in KAR 30-63-23[b][3]) periodically reviews any use of restrictive interventions or psychotropic medication for or by the person to ensure the provisions of KAR 30-63-23 are met, and the provider is responsive to any findings or recommendation by that team.
*Required education and training of personnel involved in authorization and administration of restrictive interventions: Required Restrictive Intervention Training:
KDADS staff monitors waiver providers for evidence of staff training on the following standards in the Person-
Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan.

1.The participant, his/her guardian and support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.
2.Staff are knowledgeable about and responsible to the person's health services and equipment needs.
3.Staff know how to access the Adult Protective Services contact number; and are knowledgeable about how to identify and report instances of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse.
4.Staff are trained in CPR and first aid are present whenever services are provided.
5.Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
6.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved and are consistently providing related positive behavioral supports.

All staff are required to have been trained on the appropriate use of restrictive interventions, and KDADS staff reviews training records onsite and conducts interviews with staff to determine training has been completed and each individual can demonstrate understanding and implementation of the training. A certified recognized behavior intervention training is required if an individual has restrictive interventions in their plan as an approvable intervention.

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:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restrictive interventions. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

•Methods for detecting use of seclusion and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restrictive interventions) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38- 2226.
All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

•How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1.AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2.Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3.Trend analysis on each adverse incident.
4.Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5.Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

•The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

•The frequency of oversight:

Oversight is ongoing, as indicated in the AIR System Policy and Adverse Incident Monitoring Standard

Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:
1.Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2.Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3.Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The State does not permit or prohibits the use of seclusion

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

- **The use of 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).

•Alternative methods to avoid the use of seclusion:
Participants have the right to be free from the unauthorized, unsafe, or unwarranted use of seclusion. Seclusion is prohibited for: purposes of discipline, punishment or staff member convenience. The use of seclusion is not a treatment intervention, and seclusion is prohibited as an alternative to providing adequate levels of staff to manage the participant. Participant and his/her legal representatives/guardians, and any person requested by the participant, will participate in an annual (at a minimum) Person-Centered Service Plan (PCSP) Meeting with the participant's MCO care coordinator (MCO CC) to develop a PCSP. This PCSP must be compliant with 42 CFR 441.725(b)(13)(iii) requiring documentation of less intrusive methods of meeting the need that have been tried but did not work.
The MCO CC will ensure that the participant and his/her legal guardian/representatives develop strategies to address participant's preferences that put him/her at a health or safety risk. These strategies will only be to mitigate risks to the health and safety of the participant and other individuals whom might be harmed by a dangerous act by the participant. Strategies will include the use of positive behavioral supports (PBS), other less restrictive interventions, and a clear understanding that the use of seclusion is a measure of last resort to protect the safety and health of the participant, his/her guardians, and others. When situations require behavioral intervention for a participant, methods of de- escalation, justification for authorized seclusion use and the method of seclusion applied must be documented by the involved staff. All providers shall define alternative methods of behavior management to keep a potential safety situation from escalating to emergency status. These PBS may include, but are not limited to: environmental restructuring, negative stimuli reduction, positive redirection, changing instructions, visual supports to help understanding.
Appendix G-1-e describes the process for overseeing and monitoring critical incidents and events. KDADS monitors AIRS on an ongoing basis, identifying adverse events that require follow-up investigation or remediation. KDADS reviews statewide trend analyses from AIRS aggregate-level reports across all MCOs to determine if there is a pattern in the number and percentage of adverse incidents and the potential driving forces. KDADS Managers meet regularly to share information related to patterns identified in AIR trend analyses and share with KDADS staff who conduct licensure and compliance surveys with providers. This ensures KDADS staff has necessary information related to adverse incident trends associated with specific providers when they conduct licensing visits, review: provider documentation, participant records to determine if trends require monitoring for compliance to participant safeguards or remediation.
In accordance with K.A.R. 30.63.23, Medications; restrictive interventions; behavioral management, the provider shall take proactive and remedial actions to address the following in the PCSP, as a safeguard against the use of seclusion: 1.Person's history of decision-making
2.Possible long and short-term consequences associated with poor decision making? 3.Possible long and short-term consequences of increased direction/control by staff or system? 4.Trade-offs of continuing the current situation?
5.Existence of safeguards to protect the person's rights.
6.Should more control/direction be provided? If yes, describe proposed support causing the least intrusion while adequately protecting the participant.
To avoid use of seclusion, KDADS reviews provider policies, procedures, training & documentation for evidence that all potentially effective less restrictive alternatives were tried & proven ineffective. KDADS conducts reviews to identify evidence of informed consent that includes information about PBS programming, environmental modifications, accommodations, and services available from the provider. Informed consent shall also include: complete review of the risks, benefits and side effects prior to any restraints and/or seclusion including psychotropic medications, required initial and ongoing assessment and responsive modifications are completed.
•Methods for detecting the unauthorized use of seclusion:
Each incident of seclusion will be entered into AIRS to identifying unauthorized use of seclusion. KDADS staff monitors each use of seclusion and conducts analysis to determine unauthorized use and contacts the participant's (MCO) to discuss any potential unauthorized use. This information will be used by KDADS to identify and address any negative trends in the use of seclusion if the situation warrants intervention and remediation. Additionally, the CDDO monitors for compliance with regulatory standards and statute to

assure protection from unauthorized use of seclusion. The MCO CC will conduct a review within 30 calendar days of the PCSP's implementation to determine the effectiveness of defined interventions and to discuss if adjustments to the restrictive interventions plan should be made with the input of the participant's designated team members to include parent/legal guardian and care coordinator. A team meeting may be convened at any time to review and possibly make changes in the use of restrictive interventions, including seclusion. Any plan developed by the team shall be signed by the participant's parent/legal guardian to document his/her approval. No plan shall be implemented without the participant's parent/legal guardian's consent.

Following this initial review, on-going review of use of restrictive interventions will be part of the PSCP review annually or more often as deemed necessary by the designated team members.

•The protocols that must be followed when seclusion is employed (including the circumstances when their use is permitted) and how its use is authorized:

Seclusion should only be used when all less restrictive methods of intervening have been exhausted and are limited to situations in which there is serious, probable and imminent threat of bodily harm to self or others by a person with the present ability to cause such harm. Seclusion is not allowed for the sole purpose of mediating destruction of property and must never be used as a punitive form of discipline or as a threat to control or gain compliance of a person's behavior. In all situations less restrictive alternatives including, but not limited to, PBS, constructive, non-physical de- escalation and re-structuring of the environment shall be considered prior to initiating seclusion, and all such use will be compliant with Article 63:Developmental Disabilities- Licensing Providers of Community Services.

•The practices that must be employed to ensure the health and safety of individuals:

1.If a participant is known to have any medical condition such that seclusion might endanger his/her health and safety,
use of seclusion is prohibited.

2.KDADS is responsible for ensuring providers are in compliance with regulated safeguards through initial approval and as needed review of agency policies and procedures & as needed on-site in-person reviews with persons served by the agency. KDADS monitors & assures compliance with, but not limited to K.A.R.s including:

a. K.A.R. 30-63-21. Person-Centered Support Planning
b. K.A.R. 30-63-22. Individual Rights & Responsibilities
c. K.A.R. 30-63-23. Medications; restrictive intervention; BMC
d. K.A.R. 30-63-24. Individual Health
e. K.A.R. 30-63-25. Staffing; abilities; staff health
f. K.A.R. 30-63-29. Records

3.Seclusion shall be administered only when needed to ensure safety of the participant and/or other individuals in the immediate environment, and only when needed to prevent an emergency;

4.Seclusion shall be administered only for the period of time necessary to accomplish its purpose and using no more force than is necessary; and

5.Prioritize prevention of harm to the participant if seclusion is used.

•Required documentation concerning the use of seclusion: Qualified,trained staff must meet requirements the following requirements:

1.Meet all the required training, licensing and certification requirements for the position/job function they perform (as documented by the appropriate licensing and hiring agencies); and

2.Complete, document the minimum required initial and annual training approved by KDADS for the use of restraint, restrictive intervention and seclusion; and

3.Documented competencies for the use of the restraint, restrictive interventions and seclusion both initially and annually (on file with the hiring agency or home).

When seclusion is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the seclusion, as follows:

1.Description of the antecedents (e.g. environmental conditions, activity, who was working with the participant, other individuals in the area) immediately preceding the use;

2.The specific behavior being addressed (e.g. number of occurrences, duration, description based on operational definition);
3.The alternative strategies used to de-escalate the situation prior to use (e.g. sensory stimulation, choices, redirect to preferred activity);
4.How the seclusion ended, including physical, medical and behavioral status of the participant (e.g. injuries, medical care provided, 10 seconds of calm and discontinuation of seclusion);
5.What happened after implementation of seclusion (e.g. participant demonstrated behavior again, participant left the room);
6.From on-set of behavior to discontinuation of the seclusion, staff reflect on and document the PCSP strategies they would implement again, or they would use differently;
7.Notify MCO CC, as identified in the PCSP;
8.Notify parent/legal guardian, as identified in the PCSP.
•Education and training requirements that personnel who are involved in the use of seclusion must meet: All service providers implementing seclusion must be properly trained and knowledgeable of the following:
1.Methods of safely escorting the participant;
2.Methods for safely implementing seclusion (e.g., locking a seclusion room door to prevent the participant from leaving the seclusion area);
3.Supervision of the participant while in seclusion; 4.Understanding of rules governing seclusion practices;
5.Training is conducted within specific timelines of a nationally recognized, best practice training curriculum specific to seclusion and should include, at a minimum:
a.Proper use of PBS, techniques and strategies designed to minimize and prevent the need for use of seclusion, such as observing participant and staff behaviors, potentially distressing events, and environmental factors that may trigger emergency safety situations requiring the use of seclusion; PBS includes the use of nonphysical intervention skills such as de-escalation, mediation and conflict resolution, active listening and other verbal and observational methods to detect and prevent emergency safety situations;
b.Safe use of seclusion;
c.Physical safety during emergencies;
d.Effects of seclusion on the participant, restrained physical signs of distress, and need for medical attention;
e. Simulated experience employing seclusion;
f. Proof of appropriate training should be documented in provider staff's personnel file;
g. Methods to explain the use of seclusion to parents or caregivers of the participant;
h. Documentation and notification procedures.
All training programs and materials used by a licensed provider will be available for review by CMS, the State Medicaid Agency (KDHE), and KDADS. KDADS staff review training records & interview to ensure compliance with mandatory training. Staff must be able to demonstrate understanding of the training.

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:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of seclusion. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

•Methods for detecting use of seclusion and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of seclusion) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

•How data are analyzed to identify trends and patterns and support improvement strategies: KDADS will monitor data within AIR to assess:
1.AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2.Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3.Trend analysis on each adverse incident.
4.Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5.Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

•The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.
Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.
•The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1.Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2.Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3.Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

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.

The entity or entities responsible for ongoing monitoring of participant medication regiments.
Kansas Department for Aging and Disabilities Services Community Supports and Programs (KDADS) Regional Field Staff.

•The scope of monitoring.
Each licensed entity shall maintain records in accordance with K.A.R. 30-63-29; Records.
(a) A provider shall maintain records for each person served. These records shall include the following:
(4) a health profile, which shall be reviewed for accuracy by a licensed medical practitioner at least every two years, and shall include the following:
(A) notations regarding the person's health status;
(B)any medications the person takes; and
(C) any other special medical or health considerations which might exist for that person.

Monitoring is designed to specifically focus on the use of psychotropic medication. The following regulated safeguards are monitored for compliance by the licensed provider.
K.A.R. 30-63-23. Medications; behavioral management committee.

•Methods for conducting monitoring.
KDADS Regional Field Staff are responsible for ensuring compliance with regulated safeguards through initial approval and on-going review of agency policies and procedures and regularly scheduled on-site in-person reviews with persons served by the agency. KDADS Regional Field Staff monitor and assure compliance with:
K.A.R. 30-63-21. Person-Centered Support Planning
K.A.R. 30-63-22. Individual Rights and Responsibilities
K.A.R. 30-63-23. Medications; restrictive intervention; behavioral management committee
K.A.R. 30-63-24. Individual Health
K.A.R. 30-63-25. Staffing; abilities; staff health
K.A.R. 30-63-29. Records
Additionally, the Community Developmental Disability Organization monitors for the above areas of compliance through the Quality Assurance Process, pursuant to regulation.

•Frequency of monitoring.
Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:
(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.

•How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices.
Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS Regional Field Staff.

Medication
Training:
The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through

interview and on-site monitoring during the Quality Review process.
1.The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.
2.Staff are knowledgeable about and responsible to the person's health services and equipment needs.
3.Staff are aware of the medications used by the person; are knowledgeable of the purpose and potential side effects of the medications; and know how to respond effectively if negative side effects occur.
4.Any administration of medication or other nursing tasks or activities are performed only by staff to whom a nurse has trained and delegated the duty and under the nurse's supervision.
5.Staff trained in CPR and first aid are present whenever services are provided.
6.Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
7.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

•Second line monitoring with regard to use of behavior modifying medications will be reviewed by a behavior management committee established by the provider which meets the criteria established in K.A.R. 30-63-23. Oversight of compliance with the above regulatory standards and statute is conducted by the KDADS Regional Field Staff through on-going, on-site, and in-person review of Person-Centered Support Planning and compliance with regulatory standards. Additionally, the Community Developmental Disability Organization monitors these areas of compliance through the Quality Assurance Process.

KDADS conducts on-site, in-person reviews at a minimum quarterly. In the event during the review process, QMS staff discover potentially harmful practices, the QMS staff will issue a finding and request for remediation and/or corrective action plan. QMS staff will require providers to include training as part of the remediation and/or correction plan.

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.

The state agency (or agencies) responsible for oversight.
Kansas Department for Aging and Disability Services - Community Supports and Programs (KDADS) is responsible for oversight and follow-up of appropriate medication management for participants. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

•How state monitoring is performed and how frequently.
Statewide/Regional/Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced. The state has a system intervention process in place that allows participants across the state 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. This systems integration process involves establishing relationships between parties that result in common goals, mission, and philosophy.

Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS and staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement.

•How the state monitoring program gathers information concerning potentially harmful practices and employs such information to improve quality.
Oversight of compliance with regulatory standards and statute is conducted by the KDADS Regional Field Staff through on-going, on-site, and in-person review of Person-Centered Support Planning and compliance with regulatory standards. Specifically, KDADS Regional Field Staff monitor for the use of 'out-dated' psychotropic medication. Identified issues of non-compliance are directed to the appropriate agency by KDADS Regional Field Staff for follow-up and improvement.

The KDADS Regional Field Staff monitor for compliance with the following regulations to ensure participant medications are managed appropriately and for identification and remediation of potentially harmful practices. These regulations include:
K.A.R. 30-63-21. Person-Centered Support Planning
K.A.R. 30-63-22. Individual Rights and Responsibilities
K.A.R. 30-63-23. Medications; restrictive interventions; behavioral management committee
K.A.R. 30-63-24. Individual Health
K.A.R. 30-63-25. Staffing; abilities; staff health
K.A.R. 30-63-29. Records

Additionally, the Community Developmental Disability Organization monitors the above areas of compliance through the Quality Assurance Process.

Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP of Operating Agency for review and approval/denial.
KDADS Program Manager and Assistant Director present quality reports(quarterly and annually) to the Kansas Department of Health and Environment (KDHE)via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). Additionally, KDADS is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise.
Whenever a quality reviewer encounters an IDD participant with an identifiable health and/or welfare issue, including medication management issues, the reviewer either:
1) makes a referral to APS if, in the reviewer's and his or her supervisor's opinion, the issue involves abuse, neglect, or exploitation of the participant, or
2) reports concerns to the MCO or contact person at the managed care entity if the situation is of concern but does not warrant, in the reviewer's opinion, an APS referral. The same standard is used in reporting concerns of potential abuse, neglect, and exploitation to KDADS LCE.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

The state's policies concerning the administration of medication to individuals who are unable to self-administer and the responsibilities of providers for overseeing self-administration.
Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:
(a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:
(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.
(c) A provider shall train staff who shall be responsible to implement the service provider's written policies and procedures for carrying out medication administration, including the following:
(1) Self-administration by any person;
(2) medication checks and reviews;
(3) emergency medical procedures; and
(4) any other health care task.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS/CSP Regional Field Staff.

•If applicable, the training/education that non-medical waiver providers must have in order to administer medications to participants who cannot self-administer and the extent of the oversight of these personnel by licensed medical professionals.
Each licensed entity is responsible for developing and monitoring participant medication regimens, the methods for conducting monitoring and the frequency of monitoring. Additionally, each licensed entity must assure the state of compliance with the Nurse Practice Act [K.S.A. 65-1124] for providing auxiliary patient care services under the direction of a person licensed to practice medicine or the supervision of a registered professional nurse or a licensed practical nurse. KDADS monitors for licensing compliance with K.A.R. 30-63-25. Individual health:
(a) A provider shall assist each person served, as necessary, in obtaining the medical and dental services to which the person has access and that may be required to meet the person's specific health care needs, including the following:
(b) Non-licensed personnel shall administer medications and perform nursing tasks or activities in conformance with the provisions of K.S.A. 65-1124, and amendments thereto.
(c) A provider shall train staff who shall be responsible to implement the service provider's written policies and procedures for carrying out medication administration, including the following:
(1) Self-administration by any person;
(2) medication checks and reviews;
(3) emergency medical procedures; and
(4) any other health care task.

Medication regimens are developed by qualified medical personnel according to the individual's specific medical needs as authorized by licensed medical professionals. Training requirements for personnel providing medication administration and restrictive interventions will comply with agency policies and procedures approved by and monitored by KDADS Regional Field Staff.

Medication
Training:
The field staff monitors for staff training of the following standards in the Person-Centered Support Plan and evidence services and supports are provided in accordance with the Person-Centered Support Plan through interview and on-site monitoring during the Quality Review process.
1.The person, his/her guardian and the support network have ongoing, individually-appropriate opportunities to learn about his/her individual rights and responsibilities, including at least annual training offered by the provider.
2.Staff are knowledgeable about and responsible to the person's health services and equipment needs.
3.Staff are aware of the medications used by the person; are knowledgeable of the purpose and potential side effects of the medications; and know how to respond effectively if negative side effects occur.
4.Any administration of medication or other nursing tasks or activities are performed only by staff to whom a nurse has trained and delegated the duty and under the nurse's supervision.
5.Staff trained in CPR and first aid are present whenever services are provided.
6.Staff have sufficient knowledge, competence and training to serve the person without oversight by another staff before working alone.
7.If there is a restrictive intervention or psychotropic medication being used as a behavior support for or by the person, staff have been trained in the appropriate use of the support, are accurately documenting the frequency and severity of the behavioral issue involved, and are consistently providing related positive behavioral supports.

In accordance with KS statute 65-1124 and 65-6201, Individuals in need of in-home care may receive health maintenance activities, which include medication administration; (m) performance of a nursing procedure by a person when the procedure is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgment and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse.

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:

Providers must report all medication errors that result in emergency medical treatment or incident. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

The State has designed a critical incident reporting system called Adverse Incident Reporting System (AIR). KDADS quality management team will be responsible for the administration and oversight of this reporting process.

The critical incident reporting and review process is designed to facilitate ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies licensed and/or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices.

Each medication error incident shall be reported using the AIR system within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS.

Upon receipt at KDADS, email notification is sent to the appropriate program staff as determined by the provider type. The individual MCO identified on the form is notified at the same time. Reporting parameters, including timeliness and content will be determined by contractual requirements.

All reportable critical incidents shall be documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports are reviewed jointly by the KDADS quality team and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS policies and procedures.

If it is determined that an investigation is warranted (including those events designated in Article 63 of the DDRA, 30-63-23, the incident will be investigated by KDADS quality team for confirmation of incidence and work with the MCOs for provider remediation. As a result, the provider may be asked to submit a written corrective action plan. If the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within a specified time line from the date of the initial critical incident, the provider's license may be revoked.

(b) Specify the types of medication errors that providers are required to *record:*

Providers must report all medication errors that result in emergency medical treatment or incident. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long Term Care Committee Meeting.

(c) Specify the types of medication errors that providers must *report* to the State:

Licensed providers are responsible for reporting any medication errors resulting in injury to the participant which require emergency medical services, hospitalization or death to DCF Adult Protective Services and KDADS.

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.

The Kansas Department for Aging and Disability Services-Community Supports and Programs is responsible for oversight and follow-up of waiver provider agencies' performance in administering participant medications.

•When oversight is not conducted by the Medicaid agency or the operating agency (if applicable), the process to communicate information and findings to the Medicaid agency or the operating agency.
Information and findings are reported to KDHE (Kansas Department of Health and Environment) during the Long Term Care Committee Meeting.

Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director of KDADS staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment (KDHE) via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement. Additionally, KDADS is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise.

•Monitoring methods that include the identification of problems in provider performance and support follow-up remediation actions and quality improvement activities.
Statewide/Regional/Provider data is compiled, trended, reviewed, and disseminated to providers through the Performance Improvement Analysis Process. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests and/or technical assistance to remediate negative trending are included in annual provider reports where negative trending is evidenced. The state has a system intervention process in place that allows participants across the state 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. This systems integration process involves establishing relationships between parties that result in common goals, mission, and philosophy.

The following Performance Improvement Analysis Process occurs on an annual basis.
1. Performance Improvement Data Aggregation (Central Office Performance Improvement Program Manager)
2. Performance Improvement Analysis Process including:
   a. Community Choice Reflection Team (100% consumer members) review of statewide data versus local provider trends)
   b. Performance Improvement Review Committee (Central Office PI Program Manager and Regional KDADS field staff)
   c. Performance Improvement Executive Review Committee (Central Office Assistant Director, Performance Improvement Program Manager and waiver program managers.)
3. Performance Improvement Waiver Report provided to Kansas Department of Health and Environment via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

•How data are acquired to identify trends and patterns and support improvement strategies.
Data gathered by KDADS Regional Staff during the Quality Survey Process is provided quarterly to the KDADS Performance Improvement Review Committee [Chaired by the Performance Improvement Program Manager / staffed by PI Staff statewide] for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually)

which is submitted to the Performance Improvement Executive Committee [Chaired by the Assistant Director KDADS) staffed by Waiver Program Managers, QA Program Manager and PI Program Manager]. The Performance Improvement Executive Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS, the Medicaid Operating Agency, for review and approval/denial and sent to the Kansas Department of Health and Environment via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval/denial from the Director of KDADS would be returned to the Performance Improvement Executive Committee for corrective action or planning for implementation of improvement. Additionally, KDADS is in attendance at the monthly Long Term Care Committee meeting to provide updates with regard to waiver quality processes and HCBS issues as they arise. These surveys, reviews and remediation 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 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.

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 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: Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)	**Annually**	**Stratified** Describe Group:
	☒ **Continuously and Ongoing**	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of unexpected deaths for which the appropriate follow-up measures were taken N=Number of unexpected deaths for which the appropriate follow-up measures were taken 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: Community Developmental Disability Organizations (CDDOs); 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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 Interviews 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify:	**Annually**	X **Stratified** Describe Group: Proportionate by MCO

Community Developmental Disability Organizations (CDDOs); Managed Care Organizations (MCOs)		
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures 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: Community Developmental Disability Organizations (CDDOs); 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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames

D=Number of participants reported critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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):*
X **State Medicaid Agency**	**Weekly**	X **100% Review**
X **Operating Agency**	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
X **Other** Specify: MCO's Managed Care Organizations	**Annually**	**Stratified** Describe Group:
	X **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 measures results as determined by the State.	☒ **Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures N = Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures D=Number of reported critical incidents.

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

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

☒ **Other** Specify: 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: Managed Care Organizations (MCOs)participate in analysis of this measure's results as determined by the State.	☒ **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):*

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 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 MCO's participate in analysis of this measure's results as deteremined by the State.	☒ **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 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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCO's)	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: KanCare MCO's participate in analysis of these measures results as determined by the State	X **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:
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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other** Specify: KanCare Managed Care Organizations (MCOs)	**Annually**	X **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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
X **Other** Specify: KanCare MCOs participate in analysis of these measures results as determined by the State	X **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):*
X **State Medicaid Agency**	**Weekly**	**100% Review**
X **Operating Agency**	**Monthly**	X **Less than 100% Review**
Sub-State Entity	X **Quarterly**	X **Representative Sample** Confidence Interval = 95%
X **Other**	**Annually**	X **Stratified**

Specify: KanCare Managed Care Organizations (MCOs)		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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Other** Specify: KanCare MCOs participate in analysis of the measure's results as determined by the State	X **Annually**
	Continuously and Ongoing
	Other Specify:

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

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.
Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As inclusion of the IDD services were incorporated into the KanCare program, staff of the three plans have engaged with state staff to ensure a strong understanding of the Kansas' waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in 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 process 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 is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

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

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Sub-State Entity	☒ **Quarterly**
☒ **Other** Specify: Community Developmental Disability Organizations (CDDOs); KanCare Managed Care Organizations (MCOs)	☒ **Annually**
	Continuously and Ongoing
	Other Specify:

c. Timelines

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

- **No**

  Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

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, the Frail Elderly (KS.0303), IDD (KS.0224), Physical Disability (KS.304), Serious Emotional Disturbance (KS.0320), Autism (KS.0476) and TBI waiver population (KS.4164) as part of their Quality Improvement Strategy (QIS).
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 ,the KanCare Managed Care Organizations and contracted assessor organizations to ensure interagency monitoring.
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 Adverse 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 AIRS, 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):*
X **State Medicaid Agency**	**Weekly**
X **Operating Agency**	**Monthly**
Sub-State Entity	X **Quarterly**
X **Quality Improvement Committee**	X **Annually**
X **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 currently 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.

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 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, inculding:
a.Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
b.As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) 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, quality, efficiency, coordination of care, and the cost of care.

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. The key component of that collaboration will be through the 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.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.
The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:
a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including: 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.

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 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):*
X **State Medicaid Agency**	**Weekly**	X **100% Review**
X **Operating Agency**	**Monthly**	**Less than 100% Review**
Sub-State Entity	X **Quarterly**	**Representative Sample** Confidence Interval =
X **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):*
X **State Medicaid Agency**	**Weekly**

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

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):*
X **State Medicaid Agency**	**Weekly**	X **100% Review**
X **Operating Agency**	**Monthly**	**Less than 100% Review**
Sub-State Entity	X **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:

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

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' 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**
	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 established interagency monitoring 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 that engages program management, contract management and financial management staff of both KDHE and KDADS.

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- **No**

Yes

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

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).

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 state interagency monitoring, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of interagency monitoring.

K.S.A. 39-1801 et.al, aka The Developmental Disabilities Reform Act (DDRA) mandates the establishment of a system of funding, quality assurance and contracting. Further, the statute requires an independent, professional review of the rate structures on a biennial basis resulting in a recommendation to the legislature regarding rate adjustments.

The recommendation shall be adequate to support:
A)A system of employee compensation competitive with local conditions,
B)training and technical support to attract and retain qualified employees,
C)a quality assurance process which is responsive to consumer's needs and which maintains the standards of quality service. The State Medicaid agency solicits public comments regarding the rate determination methods through publication in the Kansas
Public Register. This rate determination method is used for all IDD services regardless of whether the service is reimbursed through a tiered rate or a single rate.

Throughout the history of the Kansas IDD waiver, Kansas has used tiered rates to reimburse providers of many waiver services including day and residential supports. The initial rates were developed based on the recommendations of an actuarial contracted with by the State.

In 1995, the Kansas Legislature passed the Developmental Disabilities Reform Act (DDRA). Among other things, as stated above, the Act requires KDADS to conduct biennial rate studies. A requirement of the study is to make recommendations to the Kansas Legislature regarding the adequacy of reimbursement rates.

Based on the results of these rate studies, the Kansas Legislature, in the past, has appropriated money to the Department For Aging and Disability Services for the specific purpose of adjusting reimbursement rates.

A sheet that includes all rates for all waiver services is available to providers and participants upon request.

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.

Under KanCare, the State sets the floor HCBS service rates which serve as the minimum MCOs are required to pay providers. These rates, as established by the State, are available on the KMAP website.

Capitation rates are based on actuarial analysis of historical data for all IDD program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The MCO's are responsible for trending costs and demonstrating financial experience going forward. Based on the data collected, the MCO may request the State's review for cost adjustments.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the MCOs directly from waiver provider agencies or from Financial Management Service (FMS) agencies for those individuals self-directing their services. All claims are either submitted through the EVV system, the State's front-end billing solution, or directly to the MCO either submitted through paper claim format or through electronic format.

Claims for services required in the EVV system are generated from that system. Capitated payments in arrears are made only when the participant was eligible for the Medicaid waiver program during the month.

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.

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 service plan detailing authorized services.

All mandated services must be billed through the EVV system. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1. Individuals receiving waiver services must be determined Medicaid eligible prior to the date of service is initiated and that eligibility date reflected in the MMIS.

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 participants 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:

X **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:

Waiver payments are made for waiver services provided by Community Developmental Disability Organizations which are specifically established by state law as the instrumentalities of government to oversee and manage the delivery of services to persons with intellectual and/or developmental disabilities. This designation makes these entities public providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

  The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

  The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

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. *Select one:*

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.

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

X **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 STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. 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 I2 - a., no expenses associated with room and board are considered. The costs of room and board are not a consideration when determining reimbursement rates. Only direct service costs are considered.

Payments to providers for room and board are not processed through the Medicaid system and are therefore not included in any Medicaid cost reports.

Consistent with statute, the State contracts for a biennial rate study every other year. Although the vendor collects financial information regarding room and board, the information is excluded from any vendor recommendations regarding reimbursement rates.

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: ICF/IID

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	41917.62	9119.00	51036.62	82001.00	7428.00	89429.00	38392.38
2	41917.62	9119.00	51036.62	82001.00	7428.00	89429.00	38392.38
3	41917.62	9119.00	51036.62	82001.00	7428.00	89429.00	38392.38
4	41917.62	9119.00	51036.62	82001.00	7428.00	89429.00	38392.38
5	41917.62	9119.00	51036.62	82001.00	7428.00	89429.00	38392.38

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:	
		ICF/IID	
Year 1	9193		9193
Year 2	9193		9193
Year 3	9193		9193
Year 4	9193		9193
Year 5	9193		9193

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 (waiver years 1-3 of current waiver) of the total days of waiver coverage. The LOS was estimated by dividing 3,306,422 (the average number of days of waiver coverage) by 9,193 (the average number of consumers receiving IDD waiver services). The average length of stay is 360 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 for these

estimates is as follows:

Factor D is estimated by utilizing data from the Kansas Medicaid Management Information System (MMIS) system and reflects MCO encounter payments to providers, using a three-year average (waiver years 1-3 of current waiver). This is a projection of MCO encounters and is not 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' is projected by obtaining a three-year average (waiver years 1-3 of current waiver) of IDD waiver capitation costs minus a three-year average of MCO encounter payment costs.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is estimated by utilizing data from the Kansas MMIS system and reflects institutional MCO encounter payments to providers, using a three-year average (waiver years 1-3 of current waiver).

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is projected by obtaining a three-year average (waiver years 1-3 of current waiver) of the institutional alternative capitation costs minus a three-year average of MCO institutional encounter payment costs.

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	
Day Supports	
Overnight Respite Care	
Personal Care Service	
Residential Supports	
Supported Employment	
Financial Management Services (FMS)	
Assistive Services	
Enhanced Care Service	
Medical Alert Rental	
Specialized Medical Care	
Wellness Monitoring	

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
Day Supports Total:							**110361765.27**
Day Supports	X	15 minutes	6616	4401.33	3.79	**110361765.27**	
Overnight Respite Care Total:							**71141.81**
Overnight Respite Care	X	1 day	73	13.94	69.91	**71141.81**	
Personal Care Service Total:							**41532079.59**
Personal Care Service	X	15 minutes	2830	5222.65	2.81	**41532079.60**	
Residential Supports Total:							**224011060.62**
Residential Supports	X	1 day	5374	334.84	124.49	**224011060.62**	
Supported Employment Total:							**91550.88**
Supported Employment	X	15 minutes	53	531.50	3.25	**91550.88**	
Financial Management Services (FMS) Total:							**3863792.88**
Financial Management Services (FMS)	X	1 month	2945	10.80	121.48	**3863792.88**	
Assistive Services Total:							**375219.64**
Assistive Services	X	1 purchase	61	7.72	796.78	**375219.64**	

GRAND TOTAL:	**385348722.74**
Total: Services included in capitation:	385348722.74
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**9193**
Factor D (Divide total by number of participants):	**41917.62**
Services included in capitation:	41917.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Care Service Total:							**1137397.71**
Enhanced Care Service	X	6+ hours	111	192.14	53.33	**1137397.71**	
Medical Alert Rental Total:							**10592.91**
Medical Alert Rental	X	1 month	71	9.17	16.27	**10592.91**	
Specialized Medical Care Total:							**3754665.81**
Specialized Medical Care (RN)	X	15 minutes	13	5539.92	7.98	**574711.30**	
Specialized Medical Care (LPN)	X	15 minutes	57	6938.89	8.04	**3179954.51**	
Wellness Monitoring Total:							**139455.62**
Wellness Monitoring	X	1 visit	965	4.76	30.36	**139455.62**	
					GRAND TOTAL:		**385348722.74**
					Total: Services included in capitation:		385348722.74
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		**9193**
					Factor D (Divide total by number of participants):		**41917.62**
					Services included in capitation:		41917.62
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		360

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 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 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**110361765.27**
Day Supports	X	15 minutes	6616	4401.33	3.79	**110361765.27**	
Overnight Respite Care Total:							**71141.81**
Overnight Respite Care	X	1 day	73	13.94	69.91	**71141.81**	
Personal Care Service Total:							**41532079.59**
Personal Care Service	X	15 minutes	2830	5222.65	2.81	**41532079.60**	
Residential Supports Total:							**224011060.62**
Residential Supports	X	1 day	5374	334.84	124.49	**224011060.62**	
Supported Employment Total:							**91550.88**
Supported Employment	X	15 minutes	53	531.50	3.25	**91550.88**	
Financial Management Services (FMS) Total:							**3863792.88**
Financial Management Services (FMS)	X	1 month	2945	10.80	121.48	**3863792.88**	
Assistive Services Total:							**375219.64**
Assistive Services	X	1 purchase	61	7.72	796.78	**375219.64**	
Enhanced Care Service Total:							**1137397.71**
Enhanced Care Service	X	6+ hrs	111	192.14	53.33	**1137397.71**	
Medical Alert Rental Total:							**10592.91**
Medical Alert Rental	X	1 month	71	9.17	16.27	**10592.91**	
Specialized Medical Care Total:							**3754665.81**

GRAND TOTAL:	**385348722.74**
Total: Services included in capitation:	385348722.74
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**9193**
Factor D (Divide total by number of participants):	**41917.62**
Services included in capitation:	41917.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Care (RN)	X	15 minutes	13	5539.92	7.98	**574711.30**	
Specialized Medical Care (LPN)	X	15 minutes	57	6938.89	8.04	**3179954.51**	
Wellness Monitoring Total:							**139455.62**
Wellness Monitoring	X	1 visit	965	4.76	30.36	**139455.62**	
				GRAND TOTAL:			**385348722.74**
				Total: Services included in capitation:			385348722.74
				Total: Services not included in capitation:			
				Total Estimated Unduplicated Participants:			**9193**
				Factor D (Divide total by number of participants):			**41917.62**
				Services included in capitation:			41917.62
				Services not included in capitation:			
				Average Length of Stay on the Waiver:			360

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 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 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**110361765.27**
Day Supports	X	15 minutes	6616	4401.33	3.79	**110361765.27**	
Overnight Respite Care Total:							**71141.81**
Overnight Respite Care	X	1 day				**71141.81**	
				GRAND TOTAL:			**385348722.74**
				Total: Services included in capitation:			385348722.74
				Total: Services not included in capitation:			
				Total Estimated Unduplicated Participants:			**9193**
				Factor D (Divide total by number of participants):			**41917.62**
				Services included in capitation:			41917.62
				Services not included in capitation:			
				Average Length of Stay on the Waiver:			360

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			73	13.94	69.91		
Personal Care Service Total:							**41532079.59**
Personal Care Service	X	15 minutes	2830	5222.65	2.81	**41532079.60**	
Residential Supports Total:							**224011060.62**
Residential Supports	X	1 day	5374	334.84	124.49	**224011060.62**	
Supported Employment Total:							**91550.88**
Supported Employment	X	15 minutes	53	531.50	3.25	**91550.88**	
Financial Management Services (FMS) Total:							**3863792.88**
Financial Management Services (FMS)	X	1 month	2945	10.80	121.48	**3863792.88**	
Assistive Services Total:							**375219.64**
Assistive Services	X	1 purchase	61	7.72	796.78	**375219.64**	
Enhanced Care Service Total:							**1137397.71**
Enhanced Care Service	X	6+ hrs	111	192.14	53.33	**1137397.71**	
Medical Alert Rental Total:							**10592.91**
Medical Alert Rental	X	1 month	71	9.17	16.27	**10592.91**	
Specialized Medical Care Total:							**3754665.81**
Specialized Medical Care (RN)	X	15 minutes	13	5539.92	7.98	**574711.30**	
Specialized Medical Care (LPN)	X	15 minutes	57	6938.89	8.04	**3179954.51**	
Wellness							**139455.62**

GRAND TOTAL:	**385348722.74**
Total: Services included in capitation:	385348722.74
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**9193**
Factor D (Divide total by number of participants):	**41917.62**
Services included in capitation:	41917.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monitoring Total:							
Wellness Monitoring	X	1 visit	965	4.76	30.36	**139455.62**	
			GRAND TOTAL:				**385348722.74**
			Total: Services included in capitation:				385348722.74
			Total: Services not included in capitation:				
			Total Estimated Unduplicated Participants:				**9193**
			Factor D (Divide total by number of participants):				**41917.62**
			Services included in capitation:				41917.62
			Services not included in capitation:				
			Average Length of Stay on the Waiver:				360

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 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 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**110361765.27**
Day Supports	X	15 minutes	6616	4401.33	3.79	**110361765.27**	
Overnight Respite Care Total:							**71141.81**
Overnight Respite Care	X	1 day	73	13.94	69.91	**71141.81**	
Personal Care Service Total:							**41532079.59**
Personal Care Service	X	15 minutes	2830	5222.65	2.81	**41532079.60**	
Residential Supports							**224011060.62**
			GRAND TOTAL:				**385348722.74**
			Total: Services included in capitation:				385348722.74
			Total: Services not included in capitation:				
			Total Estimated Unduplicated Participants:				**9193**
			Factor D (Divide total by number of participants):				**41917.62**
			Services included in capitation:				41917.62
			Services not included in capitation:				
			Average Length of Stay on the Waiver:				360

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Residential Supports	X	1 day	5374	334.84	124.49	**224011060.62**	
Supported Employment Total:							**91550.88**
Supported Employment	X	15 minutes	53	531.50	3.25	**91550.88**	
Financial Management Services (FMS) Total:							**3863792.88**
Financial Management Services (FMS)	X	1 month	2945	10.80	121.48	**3863792.88**	
Assistive Services Total:							**375219.64**
Assistive Services	X	1 purchase	61	7.72	796.78	**375219.64**	
Enhanced Care Service Total:							**1137397.71**
Enhanced Care Service	X	6+ hrs	111	192.14	53.33	**1137397.71**	
Medical Alert Rental Total:							**10592.91**
Medical Alert Rental	X	1 month	71	9.17	16.27	**10592.91**	
Specialized Medical Care Total:							**3754665.81**
Specialized Medical Care (RN)	X	15 minutes	13	5539.92	7.98	**574711.30**	
Specialized Medical Care (LPN)	X	15 minutes	57	6938.89	8.04	**3179954.51**	
Wellness Monitoring Total:							**139455.62**
Wellness Monitoring	X	1 visit	965	4.76	30.36	**139455.62**	

GRAND TOTAL:	**385348722.74**
Total: Services included in capitation:	385348722.74
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**9193**
Factor D (Divide total by number of participants):	**41917.62**
Services included in capitation:	41917.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	360

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 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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**110361765.27**
Day Supports	X	15 minutes	6616	4401.33	3.79	**110361765.27**	
Overnight Respite Care Total:							**71141.81**
Overnight Respite Care	X	1 day	73	13.94	69.91	**71141.81**	
Personal Care Service Total:							**41532079.59**
Personal Care Service	X	15 minutes	2830	5222.65	2.81	**41532079.60**	
Residential Supports Total:							**224011060.62**
Residential Supports	X	1 day	5374	334.84	124.49	**224011060.62**	
Supported Employment Total:							**91550.88**
Supported Employment	X	15 minutes	53	531.50	3.25	**91550.88**	
Financial Management Services (FMS) Total:							**3863792.88**
Financial Management Services (FMS)	X	1 month	2945	10.80	121.48	**3863792.88**	
Assistive Services Total:							**375219.64**
Assistive Services	X	1 purchase	61	7.72	796.78	**375219.64**	

GRAND TOTAL:	**385348722.74**
Total: Services included in capitation:	385348722.74
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**9193**
Factor D (Divide total by number of participants):	**41917.62**
Services included in capitation:	41917.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	360

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Care Service Total:							**1137397.71**
Enhanced Care Service	X	6+ hrs	111	192.14	53.33	**1137397.71**	
Medical Alert Rental Total:							**10592.91**
Medical Alert Rental	X	1 month	71	9.17	16.27	**10592.91**	
Specialized Medical Care Total:							**3754665.81**
Specialized Medical Care (RN)	X	15 minutes	13	5539.92	7.98	**574711.30**	
Specialized Medical Care (LPN)	X	15 minutes	57	6938.89	8.04	**3179954.51**	
Wellness Monitoring Total:							**139455.62**
Wellness Monitoring	X	1 visit	965	4.76	30.36	**139455.62**	

GRAND TOTAL:	**385348722.74**
Total: Services included in capitation:	385348722.74
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**9193**
Factor D (Divide total by number of participants):	**41917.62**
Services included in capitation:	41917.62
Services not included in capitation:	
Average Length of Stay on the Waiver:	360