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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Autism Waiver

C. Waiver Number: KS.0476

D. Amendment Number:

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

E. Approved Effective Date of Waiver being Amended: 04/01/22

2. Purpose(s) of Amendment

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

To align this waiver with the submission of the State's 1915(b) application.

3. Nature of the Amendment

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

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Component of the Approved Waiver

Subsection(s)

Access and Eligibility

☐ Appendix C Participant Services

☐ Appendix D Participant Centered Service Planning and Delivery

☐ Appendix E Participant Direction of Services

☐ Appendix F Participant Rights

☐ Appendix G Participant Safeguards

☐ Appendix H

☐ Appendix I Financial Accountability

☐ Appendix J Cost-Neutrality Demonstration

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

☐ Modify target group(s)

☐ Modify Medicaid eligibility

☐ Add/delete services

☐ Revise service specifications

☐ Revise provider qualifications

☐ Increase/decrease number of participants

☐ Revise cost neutrality demonstration

☐ Add participant-direction of services

☐ Other

Specify:

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

1. Request Information (1 of 3)

A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (optional - this title will be used to locate this waiver in the finder):

Autism Waiver

C. Type of Request: amendment

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

- 3 years
- 5 years

Draft ID: KS.004.03.07

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/22

Approved Effective Date of Waiver being Amended: 04/01/22

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

- Hospital
  - Select applicable level of care
    - Hospital as defined in 42 CFR §440.10
      - If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

- Inpatient psychiatric facility for individuals age 21 and under as provided in 42 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
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:
  This amendment is being submitted simultaneously with the 1915(b) application.

Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

- A program operated under §1932(a) of the Act.
  Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.
  Specify the program:

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

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

07/05/2023
2. Brief Waiver Description

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

The purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. The goal of the Autism Waiver is to divert children from entering an inpatient psychiatric facility for individuals age 21 and under as provided in 42CFR440.160 by providing parental support and training. Autism Waiver services are available to children who have received a diagnosis of an Autism Spectrum Disorder (ASD), including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a licensed Medical Doctor or Ph.D. Psychologist using an approved Autism specific screening tool. Since research has shown that early intensive interventions with ASD children are effective, a child must be between the age of zero through their fifth year of age upon entering the waiver and be financially eligible for Medicaid. Children must also meet the Level of Care eligibility determination conducted initially and annually by a qualified Functional Eligibility Specialist. The level of care instrument used to determine initial and annual eligibility for the Autism waiver must be the state approved functional eligibility instrument. The Kansas Autism Waiver has a service limit of four years. Kansas Autism Waiver provides three distinctive services to participants and their families. These services are: Respite Care, Parent Support and Training (peer to peer) Provider, and Family Adjustment Counseling.

Once a child has completed the four years of service or been found to be no longer eligible for the HCBS Autism Waiver, the child may transition to which ever waiver the family and the child feels will meet the needs of the child and that the child meet functional eligibility criteria.

In the case of each waiver:

HCBS Intellectual and Developmental Disability (I/DD): If the child meets the eligibility criteria, as determined by the IDD waiver, for the IDD waiver they may bypass the waitlist during their transition.

HCBS Severe Emotional Disturbance (SED): If the child meets the eligibility criteria, as determined by the SED waiver, the child may transition to the SED waiver.

HCBS Technology Assistance (TA): If the child meets the eligibility criteria, as determined by the TA waiver, the child may transition to the TA waiver.

Each waiver participant will have a Person-Centered Service Plan referred as Service Plan. The Service Plan is developed by the Managed Care Organization (MCO) and will describe waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written Service Plan. The Service Plan will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written Service Plan.

Programmatic oversight and control of the waiver is provided by Kansas Department for Aging and Disability Services (KDADS). KDADS has taken the necessary safeguards to protect the health and welfare of children receiving services under this waiver by setting adequate standards for all types of providers that furnish HCBS/Autism waiver services; those standards of any State licensure or certification requirements are met for services or for individuals furnishing services through the waiver.

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 inpatients 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 II.

I. Public Input. Describe how the state secures public input into the development of the waiver:
The Public Comment process can be found in 8.b.

Commenter: CMHCs statewide do not have expertise in serving children with Autism. SED Waiver billing should be opened up so families can choose other providers who have Autism expertise and bill under the SED Waiver. -KDADS Response: KDADS has set up a task force to provide recommendations to resolve some of the concerns raised. In addition, the agency plans to provide training for families and providers to address gap in service delivery for people with the autism.

Commenter: GT Independence recognizes the importance of the proposed amendments in respect to each of the two waivers and will provide specific comments to each waiver. -KDADS Response: - Thank you for your comment.

Commenter: Self-direction empowers individuals to have the choice to manage and control their services, choosing where, when, and how these services are delivered. -KDADS Response: -Thank you for your comment.

Commenter: GT Independence is pleased to see that KDADS proposes changes to the respite services offering a self-direction option for the Autism Waiver. GT Independence believes strongly that each participant/member be provided the opportunity to live a life of their choosing. -KDADS Response: -Thank you for your comment.

Commenter: GT Independence would request that Kansas consider making self-direction an option for all seven Kansas Medicaid 1915(c) Waivers. -KDADS Response: -Thank you for your comment.

Commenter: The State of Kansas Autism waiver should be terminated. This waiver is of low value and takes up more money in administrative fees than what is actually used by the measly 65 members it is able to serve on an annual basis. -KDADS Response: -Thank you for your comment.

Commenter: I’m looking for clarification on the part about seclusion and restraint. Are you removing that or adding it? Is it being replaced? -KDADS Response: -We are proposing to remove seclusion and restraint from the waiver.

Commenter: I would like to see more training for care attendants working with children. -KDADS Response: -We hope to see more as well.

Commenter: Once children are eligible for the waiver does this open access to the medical card and access to other services as well? -KDADS Response: - Children do receive a medical card when they are approved for the waiver if they don’t have one already.

Commenter: Can we change the number of children that are eligible and open the waiver to more than 65 children? -KDADS Response: KDADS will note the continued desired for additional waiver spots.

Commenter: Will there be any expansion for the number of children who can be served on the Autism Waiver? -KDADS Response: -KDADS will note the continued desired for additional waiver spots.

Commenter: Referring to changing the time on the waiver from three years to four years. The condition of “or” no longer applies to the Autism waiver. Can you speak more to that? -KDADS Response: -The way it reads currently is three years on the Autism waiver with an option for a fourth year. An assessment is completed every year to determine eligibility for the waiver. After the 3rd year if eligible for the Autism waiver they are ineligible for the IDD Waiver. We decided after the 4th year they qualify to move to another waiver if eligible.

Commenter: We are seeing gaps in kids with multiple diagnoses who qualify for the Autism and SED waivers and are working to figure out as a provider how to provide the most appropriate services. We suggest to raise the age limit for the
Autism waiver and the number of kids who can be on it so that kids who need these services can still be on that waiver and receive them.

**KDADS Response:** Thank you for your comment.

**Commenter:** I really like the proposed change of making respite self-directed. I also wanted to point out that several of the families I work with are starting the waiver but are not interested in ABA and it becomes a barrier of finding an agency who will provide the services but without ABA. Some families are stuck between not wanting to use the only type of therapy available or losing the waiver services.

**KDADS Response:** Thank you for your comment.

**Commenter:** The feedback I have gotten from families is that they have read up on ABA and they do not believe it is ethical or appropriate. They are looking for respite, parent support and training, counseling and other services excluding ABA.

**KDADS Response:** Thank you for your comment.

**Commenter:** Some families have already completed ABA through private insurance before coming onto the waiver so they have moved past that part of the work and need services like respite.

**KDADS Response:** Thank you for your comment.

**Commenter:** What is the income limit? Is it still based on the child’s income?

**KDADS Response:** Eligibility will continue be based on the child’s income.

**Commenter:** The limit of 65 children on the waiver statewide makes it difficult for provider agencies to justify bringing in new providers and training and hiring people to provide services.

**KDADS Response:** Thank you for your comment.

**Commenter:** Has anyone looked into other options about adding different services to the waiver besides ABA? ABA is an intense process and may be more than some families can do with their child. What other services could be under the waiver?

**KDADS Response:** ABA therapy services were removed from the waiver in 2017 and are now part of the State plan services.

**Commenter:** Who will be managing the Autism waiver?

**KDADS Response:** Matthew Beery will be in charge of the Autism waiver.

**KDADS** received no public comments from the Tribal Governments.

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**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:**

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<td>Weiter</td>
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</table>
First Name: Kurt
Title: Waiver Program Manager
Agency: Kansas Department of Health and Environment
Address: 900 SW Jackson
Address 2: Room 900 N
City: Topeka
State: Kansas
Zip: 66612-1220
Phone: (785) 296-8623 Ext: TTY
Fax: (785) 296-4813
E-mail: Kurt.Weiter@ks.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:
Last Name: Heydon
First Name: Michele
Title: KDADS HCBS Director
Agency: Kansas Department on Aging and Disability Services
Address: 503 S Kansas Ave
Address 2: 
City: Topeka
State: Kansas
Zip: 66604
Phone: 

07/05/2023
8. Authorizing Signature

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

Signature: 

State Medicaid Director or Designee

Submission Date: 

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

Last Name: 

First Name: 

Title: 

Agency: 

Address: 

Address 2: 

City: 

State: Kansas 

Zip: 

Phone: 

Fax: 

07/05/2023
Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

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 states most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)
Provide additional needed information for the waiver (optional):
Kansas has held two public stakeholder workgroups. In 2019, KDADS held a workgroup to get feedback on how we can better serve person’s with autism. A major issue that was addressed as a result of this workgroup was to submit a state plan amendment to expand credentials acceptable to serve as an Autism Specialist. The state expects to see more providers qualify to provide much needed services. The SPA was approved in 2020. In September 2021, KDADS Secretary formed another workgroup with stakeholders to identify gaps in services and develop a plan to address these gaps for Kansans with autism. Kansas expects to see changes in the current waiver once the workgroup concludes their work and amendments to the Autism Waiver will be submitted as necessary to reflect the recommendations of the group.

The public comment session for the Autism Waiver ran from 10/1/2021 through 11/15/2021. The Autism Waiver Renewal Public Comment was hosted by Wichita State University and lead by KDADS staff. The public comment sessions were held at three different times: October 19, 2021 at 10 am, October 19, 2021 at 2 pm, and October 21, 2021 at 6pm. All public comments can be found at https://kdads.ks.gov/kdads-commissions/long-term-services-supports/ltss-public-comment-section. There was a total of 20 public comments. A transcription of the comments and responses are found in 6.I.

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/Long Term Services and Supports Commission

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella
agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, State Plan Amendments (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 the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.) The state leadership-level meetings occur weekly and additional meetings occur as needed.

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

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

b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.

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

d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the program and the KanCare MCO contracts, and does collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration has been through the long term care meetings, KanCare Steering meetings, joint policy meetings, are all important parts 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 the program, and the interagency monitoring (including the SSMA’s monitoring of delegated functions to the Operating Agency) is guided by the joint long term care (LTC) meetings. A critical component of that strategy is the engagement of the LTC stakeholders, 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 LTC meetings – is on a quarterly basis. Continuous monitoring is being conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure.

All oversight activities delegated by KDHE to KDADS are expressly identified in the standard operating procedures as well as in the body of the Memorandum of Understanding (MOU) between KDHE and KDADS. The MOU will be reviewed and updated at a minimum 5 years from the effective date (section XIV.a). This does not preclude the parties from reviewing and updating the MOU at any time after the effective date by mutual agreement of the parties. Also the SOP’s can be updated at any time without having to amend the MOU.

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:

The assessing entity is a contracted entity to complete the waiver enrollment request with the participants and submits the request to KDADS for processing. The assessing entity is a contracted entity to provide the level of care assessment and upon completion submitting them to KDADS for determination. The waiver determination is made by KDADS and KDHE for all initial eligibility and continued eligibility requests. The MCOs engage the child and family or responsible adult to develop a Person-Centered Service Plan for the participant. The MCOs are responsible for ensuring paid support staff or other professionals carry out the Service Plan that supports the child’s functional development and inclusion in the community. Once the MCOs complete the Person-Centered Service Plan with the child and family or responsible adult, a review is completed to ascertain the specific services, frequency and duration required to meet the needs of the child as identified in the service plan. Some approved waiver services do require prior authorizations before the services are administered. The MCOs provide utilization management and oversight of the service plans for waiver participants.

KDHE contracts with a Medicaid Fiscal agent to enroll providers in the Medicaid program in compliance with federal law. The Medicaid fiscal agent and KDHE review the provider application prior to approving the provider’s enrollment in the Medicaid program. The MCOs contract and credential providers within their network.

KDHE contracts with an EQRO to perform the EQRO defined functions for managed care.

The KDHE DHCF contracted actuary analyzes the MCOs paid claims to determine the capitation rate (PMPM) for the Autism waiver.

KDHE DHCF’s contract with the MCOs requires the MCOs to provide medically necessary services to eligible Medicaid members. The MCOs are contractually required to provide reporting to the State and address quality concerns.

- 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:

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Appendix A: Waiver Administration and Operation

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

Kansas Department of Health and Environment (KDHE) holds the contract for the Managed Care Organizations (MCO) and KDHE completes regular quality assurance and oversight activities of the MCO's carrying out the contract. KDADS manages the qualified assessor contract and KDHE monitors KDADS Quality Assurance reviews of the Level of Care assessing entity.

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 and the state’s KanCare managed care organizations, are monitored through the 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.

All functions delegated to contracted entities are included in the State’s comprehensive quality strategy review processes. In addition, the SSMA and State operating agency KDADS will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement includes oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related CMS 1915(b) waiver regulations and guidelines and Kansas statutes and regulations, and related policies. Included in the QIS is an ongoing assessment of the results of onsite monitoring and reviews with a sample of HCBS waiver participants.

KDADS oversees the contract with the qualified assessor to ensure that assessors meet current educational and training requirements to conduct the Vineland-3 assessment with children in Kansas. KDADS oversees the process to ensure the qualified assessor completes a Vineland-3 assessment every 365 days to determine functional eligibility while the child is on the Autism waiver. The Level of care assessment, the Vineland-3 assessment, is completed by the assessing entity, reviewed and approved by the KDADS Program Manager. Functional determination decisions are sent to KDHE for review and financial eligibility determination.

KDHE as the SSMA manages the contracts with the Managed Care Organizations in Kansas. KDADS oversees a quarterly review process with each MCO in Kansas. KDADS oversees this quarterly review process to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing.

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Vineland-3 assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team requires the contracted assessor to provide the following documents for each child assessed:
1. Vineland-3 assessments
2. Referral form from KDADS for the assessment.
3. Approved form from KDADS Program Manager
4. Recommended Service Plan

KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing.

### 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.

<table>
<thead>
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<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
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<tbody>
<tr>
<td>Participant waiver enrollment</td>
<td>X</td>
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<tr>
<td>Waiver enrollment managed against approved limits</td>
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<td>X</td>
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<td>Waiver expenditures managed against approved levels</td>
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<th>Function</th>
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<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
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<tr>
<td>Level of care evaluation</td>
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<tr>
<td>Review of Participant service plans</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Prior authorization of waiver services</td>
<td>X</td>
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<tr>
<td>Utilization management</td>
<td>X</td>
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<tr>
<td>Qualified provider enrollment</td>
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<tr>
<td>Execution of Medicaid provider agreements</td>
<td>X</td>
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<td>Establishment of a statewide rate methodology</td>
<td>X</td>
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<tr>
<td>Rules, policies, procedures and information development governing the waiver program</td>
<td>X</td>
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<tr>
<td>Quality assurance and quality improvement activities</td>
<td>X</td>
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Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Meeting minutes
If ‘Other’ is selected, specify:
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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
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- [x] Continuously and Ongoing
- [ ] Other
  - Specify:

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

Data Source (Select one):
- [ ] Other
  - Specify: Quality Review Reports

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

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

Number of waiver amendments and renewals

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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

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<td>☒ Operating Agency</td>
<td>☐ Monthly</td>
</tr>
</tbody>
</table>
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 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 part of the KanCare program, staff of the three MCOs are engaged with State staff to ensure 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 team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring measures. These processes are monitored by both program managers and other relevant State and MCO staff.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy policy. 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 evidence has shown noncompliance of 86% or below for an assurance.

### ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>x State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>x Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>[ ] Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>[ ] Other</td>
<td>Annually</td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
<tr>
<td>[ ] Continuously and Ongoing</td>
<td></td>
</tr>
<tr>
<td>[ ] Other</td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age Limit</th>
<th>No Maximum Age Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged or Disabled, or Both - General</td>
<td>Aged</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disabled (Physical)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disabled (Other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td>Brain Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medically Fragile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technology Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability or Developmental Disability, or Both</td>
<td>Autism</td>
<td>0</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developmental Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intellectual Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serious Emotional Disturbance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

To be eligible for the HCBS/Autism Waiver services, the child must have a diagnosis of Autism Spectrum Disorder, (ASD) including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a Medical Doctor or Ph.D. Psychologist. The State relies on Ph.D. level psychologists or a licensed physician for a diagnosis of an Autism Spectrum Disorder and the most appropriate diagnostic tools that they use based on their observations. The diagnosis is supplied to KDADS along with applicable supporting documentation.

**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:
If the child will require additional waiver services after exiting the HCBS/Autism Waiver, the KanCare MCO will assist the child/family in gaining access to other appropriately identified services. The family may choose to transition the child to the HCBS/IDD waiver, HCBS/SED waiver or HCBS/TA waiver, providing the established criteria for the waiver the family has chosen meets established guidelines. The KanCare MCO and/or the Targeted Case Manager (TCM) if one is assigned via the IDD or SED programs will contact the appropriate agency 6 months prior to the child transitioning off the HCBS/Autism waiver to develop a transition plan to the appropriate waiver program or other service options. Only members who are IDD eligible are able to receive TCM services.

Children may utilize services provided through IDEA with their Individual Education Plan (IEP) Kan-Be Healthy (EPSDT), their regional Community Developmental Disabilities Organization (CDDO) or other available programs. Children meeting program-specific eligibility requirements may receive appropriate services through the Early Childhood Intervention Programs (ECI), the Local Education Agency (LEA) program or services meeting the medical necessity criteria under EPSDT provisions.

A child may be offered services prior to turning age six (6). A child can receive up to four years of service on the waiver and could be on the waiver until age nine (9).

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:
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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>82</td>
</tr>
<tr>
<td>Year 2</td>
<td>82</td>
</tr>
<tr>
<td>Year 3</td>
<td>82</td>
</tr>
<tr>
<td>Year 4</td>
<td>82</td>
</tr>
<tr>
<td>Year 5</td>
<td>82</td>
</tr>
</tbody>
</table>

**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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>65</td>
</tr>
<tr>
<td>Year 2</td>
<td>65</td>
</tr>
<tr>
<td>Year 3</td>
<td>65</td>
</tr>
<tr>
<td>Year 4</td>
<td>65</td>
</tr>
<tr>
<td>Year 5</td>
<td>65</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Institutional Stay</td>
</tr>
<tr>
<td>Military Inclusion</td>
</tr>
</tbody>
</table>

*Appendix B: Participant Access and Eligibility*

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

**Temporary Institutional Stay**

**Purpose** *(describe)*:

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

**Describe how the amount of reserved capacity was determined**: 

There reserved capacity was determined based on historical utilization and the fact there have not been more than two individuals who have requested it for the same time period.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>2</td>
</tr>
<tr>
<td>Year 2</td>
<td>2</td>
</tr>
<tr>
<td>Year 3</td>
<td>2</td>
</tr>
<tr>
<td>Year 4</td>
<td>2</td>
</tr>
<tr>
<td>Year 5</td>
<td>2</td>
</tr>
</tbody>
</table>
Purpose (provide a title or short description to use for lookup):

Military Inclusion

Purpose (describe):

The State reserves capacity for dependents and immediate family members of military personnel who have been determined program eligible to bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established Autism waiver criteria will be allowed to bypass the waitlist and access services.

Describe how the amount of reserved capacity was determined:

There reserved capacity was determined based on historical utilization and the fact there have not been more than two individuals who have requested it for the same time period.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>2</td>
</tr>
<tr>
<td>Year 2</td>
<td>2</td>
</tr>
<tr>
<td>Year 3</td>
<td>2</td>
</tr>
<tr>
<td>Year 4</td>
<td>2</td>
</tr>
<tr>
<td>Year 5</td>
<td>2</td>
</tr>
</tbody>
</table>

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:

Once the child has received a diagnosis of ASD they must also meet the level of care (functional) eligibility guidelines utilizing the State approved functional eligibility instrument. Entrance to the waiver is determined on a first come first serve basis. The date and time request for waiver services received at KDADS will be the determining factor. The number of eligible entrants into the program is limited to the number of waiver capacity allowed by funding.

The Autism Program Manager maintains a statewide "Proposed Recipient List" of those children who have a diagnosis of ASD, request Autism Waiver services, and have completed the necessary form indicating the name of the child, diagnosis, address, date of birth, phone number, and name of parent/guardian. The form can be faxed, mailed, or emailed to the Autism Program Manager where it will be date/time stamped. The date/timed stamped and/or faxed date/time will be the determining factor for the first come first serve policy. The "Proposed Waiver Recipient" list is being utilized to determine when a child will be offered services as HCBS/Autism slot becomes available. When a slot becomes available, the Autism Program Manager will send a letter to the family using the address on file notifying them of the available position. The family is given two weeks to respond to the letter informing the Program Manager if they would like to continue with the eligibility process. If the Program Manager does not receive a response, they will reach out by phone confirming receipt of the letter and the parents’ choice. If the parent indicates they would like to pursue the Autism Waiver the Program Manager will notify the contracted functional assessor that an assessment is needed. Families are given a notice of action (NOA) if the child is found either functionally eligible or functionally ineligible. The NOA also contains appeal rights.

The Autism waiver consists of a continued interest list and does have a waiting list, however, the State does not serve more than the allotted 65 at any point in time.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

   ☐ §1634 State
   ☐ SSI Criteria State
   ☐ 209(b) State

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

   ☐ No
   ☐ Yes

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

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

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

Select one:

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

Specify percentage: __________

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

Specify:

Parents and other caretaker relatives (42 CFR 435.110)
Pregnant Women (42 CFR 435.116)
Infants and Children under the age of 19 (42 CFR 435.118)
Newborn Children (42 CFR 435.117)

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

☒ A special income level equal to:

Select one:

☐ 300% of the SSI Federal Benefit Rate (FBR)
☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)
Specify percentage: □
○ A dollar amount which is lower than 300%.

Specify dollar amount: □

□ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
✚ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

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

□ Aged and disabled individuals who have income at:

Select one:

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

Specify percentage amount: □

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

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

✚ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

○ Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)
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:  

  

If this amount changes, this item will be revised.
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:
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):
SSI standard
- Optional state supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage: [ ]

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

300% of SSI

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility
Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income

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


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


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


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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):

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

Specify the entity:

- Other
  Specify:

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:
KDADS Autism Waiver Program Manager holds a Bachelors Degree.

The Qualified Assessor must meet the following requirements:

They must meet the qualifications specified by Pearson Assessments, as a level B user the assessor must meet one of the following qualifications:

"A master's degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the intended use of the assessment, and formal training in the ethical administration, scoring, and interpretation of clinical assessments.

OR
Certification by or full active membership in a professional organization (such as ASHA, AOTA, AERA, ACA, AMA, CEC, AEA, AAA, EAA, NAEYC, NBCC) that requires training and experience in the relevant area of assessment.

OR
A degree or license to practice in the healthcare or allied healthcare field.

OR
Formal, supervised mental health, speech/language, occupational therapy, social work, counseling, and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring, and interpretation of clinical assessments."

"User has a licensure to practice psychology independently, or User has completed a doctoral (or in some cases masters) degree program in one of the fields of study indicated for the test that included training (through coursework and supervised practical experience) in the administration and interpretation of clinical instruments. If neither of these qualifications are met, Users must provide proof that they have been granted the right to administer tests at this level in their jurisdiction".

*Must be able to provide proof of professional liability insurance and automobile liability insurance coverage

*Must complete KDADS approved training criteria, and

*Must successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid, and Motor Vehicle screen.

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.
A qualified Functional Eligibility Specialist conducts the level of care (functional eligibility) assessment of the child who is applying for waiver services within five (5) business days of the referral, unless a different timeframe is requested by the participant/family applying for services or their legal representative.

The Functional Eligibility Instrument (FEI) measures the personal and social skills of individuals from birth through adulthood. Because adaptive behavior refers to a participant’s typical performance of the day-to-day activities measuring personal and social skills, these scales assess what a person actually does, rather than what they are thought to be capable of performing. The FEI assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization, and Motor Skills. It then provides a composite score that summarizes the participant’s performance across all four domains.

The child must have a total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living skills, Socialization, and Motor skills) of two standard deviations below the mean of 100 (i.e., a score of 70 or below) in order to be eligible for the waiver.

Or

A total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living Skills, Socialization and Motor skills) of one standard deviation below the mean of 100 (score of 71-85), prompts the assessor to review the scores on the Maladaptive Behaviors (internal, external or total). If the child’s v-scale score on any subdomain of the Maladaptive domain is between 21-24, the child is eligible for the Waiver.

The FEI is the Autism Waiver functional eligibility tool (Level of Care Determination) to be utilized to determine functional eligibility. The FEI is a measurement of personal and social skills from birth to adulthood. The FEI focuses on four adaptive domains and one maladaptive domain: within all of the domains there are sub-domains which allow for greater in-depth holistic approach in developing the Service Plan. The following domains and sub-domains are: 1) communication, (subdomain-receptive, expressive, and written), 2) Daily Living Skills (sub-domain-personal, domestic, and community), 3) Socialization (subdomain- interpersonal relationships, play and leisure time, and coping skills), 4) Motor Skills (subdomain-fine and gross), 5) Maladaptive Behavior Index (subdomain-internalizing, externalizing, and other).

KDADS Program Manager sends offer letters to persons on the Proposed Recipient’s List during an offer round. When the family accepts the offer, the Program Manager sends referral to the assessing entity to conduct the Vineland. When the Vineland is completed, the assessing entity sends the completed Vineland to the KDADS Program Manager. The Program Manager reviews and approves program eligibility and sends to KDHE to determine financial eligibility. KDHE sends completed eligibility packet to the chosen MCO and back to KDADS.

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.
The state assessing agency screening form is utilized to screen for a variety of intensive inpatient psychiatric services. The form includes information on presenting problem, risk factors, clinical impressions, and inpatient criteria. The form is not based on a standardized tool or assessment, but solely on the self-report of the participant or participant’s family and the clinical observation and judgment of a qualified mental health practitioner. The Vineland 3 is the instrument used to assess the Level of Care (LOC) for institutional care.

Although the Vineland 3 are comparable in addressing the domains of a child’s life, the State of Kansas chooses the Vineland because the tool provides greater details in each domain, which in turn allows the assessor to identify the specific troublesome areas a child is experiencing. This is accomplished because the Vineland is a standardized tool; it guides the assessor throughout all domains by having set specific questions. The assessor must rate each question according to the following rating scale:

2 (behavior is usually or habitually performed),
1 (sometimes or partly performed),
0 (never performed).

Additionally, code N, for instance, is used when the child has never had the opportunity to perform the activity and/or behavior. A code of DK, is used when the caregiver does not know if the child preformed the activity an/ or experienced the behavior. The Vineland also provides a composite score that summarizes the individual’s performance across the domains. Therefore, Kansas views the FEI to not only be comparable or equivalent to the Mental Health Screening Instrument but to exceed it by identifying and addressing the child’s specific needs.

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:
KDADS Program Manager sends referral to the assessing entity to conduct the Vineland. When the Vineland is completed, the assessing entity sends the completed Vineland to the KDADS Program Manager. The Program Manager reviews and approves and sends to KDHE to determine financial eligibility. KDHE sends completed eligibility packet to the chosen MCO and back to KDADS.

Notice of Action- When a child is found functionally eligible or ineligible during the initial evaluation or the annual reevaluation, the child/family will receive a Notice of Action advising them of the status of their functional eligibility evaluation.

All functional eligibility documentation including the initial evaluation, the annual re-evaluation, freedom of choice and the notice of action are to be maintained in the child’s case file.

KDADS has contracted with one provider who will administer the Vineland in order to determine the level of care (LOC) for functional eligibility and assist the child/family in determining eligibility for waiver services. The following criteria apply for waiver eligibility:

1) Age - at the time of entrance to the waiver a child must be between the ages of zero (0) through age five (5) years and 11 months.

2) Diagnosis: the child must have a diagnosis of Autism Spectrum Disorder (ASD) from a Licensed Medical Doctor or Ph.D. Psychologist using an approved American Academy of Pediatrics (AAP) Autism specific screening tool.

3) LOC determination: The Vineland 3 must be completed and the child must meet the established scoring criteria in order to be determined functional eligible.

4) A child must be determined to need inpatient psychiatric facility level of care in the absence of waiver services.

5) Family Choice form: Documentation to support Parents/Guardians choice of waiver services.

6) Annual Revaluation - The need for HCBS Autism Waiver services is re-evaluated (face to face or virtually) at a minimum on an annual basis but can also be conducted at any time the family feels it is appropriate, as needs change, and/or as goals are accomplished. The Vineland is completed each time the child is assessed and follows the same process as initial eligibility.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

   Specify the other schedule:

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

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

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

The contracted state assessing agency manages reevaluation lists and provides documentation to the State for each annual reevaluation that is completed.

The State currently contracts with KVC to do the initial evaluation and reevaluation of children on the Autism Waiver. KVC provides KDADS with a list of children that are due for reevaluation. KVC also provides KDADS with the evaluation scheduled day and time and if a meeting had to be rescheduled for any reason. The Autism Program Manager verifies this list against KDAD’s Autism Waiver tracking to ensure reevaluations are completed in a timely manner.

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:

Records are maintained by the state assessing agency for performing the initial eligibility determination and annual reevaluation. The state assessing agency also supplies the State with a copy of initial eligibility determination and annual reevaluation information. 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 §74.53. It will also be maintained in the State of Kansas Medicaid Management Information System (MMIS).

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

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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 365 days of the previous Level of Care determination

N=Number of waiver participants who receive their annual Level of Care evaluation within 365 days of the previous Level of Care determination

D=Number of waiver participants who received Level of Care redeterminations

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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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 all Level of Care (LOC) determinations made by a qualified assessor

\[ \text{N} = \text{Number of all Level of Care (LOC) determinations made by a qualified assessor} \]
\[ \text{D} = \text{Number of all Level of Care determinations} \]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
assessor and assessor records

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

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

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Data Aggregation and Analysis:

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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 all Level of Care (LOC) determinations made where the LOC criteria was accurately applied  

\[ N = \text{Number of all Level of Care (LOC) determinations made where the LOC criteria was accurately applied} \]
\[ D = \text{Number of all Level of Care determinations} \]

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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Application for 1915(c) HCBS Waiver: Draft KS.004.03.07 - Jan 01, 2024 Page 55 of 204
Data Aggregation and Analysis:

Responsibility Party for data aggregation and analysis (check each that applies):

- [x] State Medicaid Agency
- [x] Operating Agency
- [ ] Sub-State Entity
- [ ] Other
  
Specify:

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

- [x] Weekly
- [ ] Monthly
- [x] Quarterly
- [ ] Annually

- [x] Continuously and Ongoing

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 remediation documentation when necessary. In addition, the performance of the contracted Functional Specialist will be monitored on an ongoing basis to ensure compliance with the state 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 agency (KDHE).

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 measures. These processes are monitored by both contract managers and other relevant State staff, depending upon the type of issue involved.

ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
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<td>[ ] Weekly</td>
</tr>
<tr>
<td>[x] Operating Agency</td>
<td>[ ] Monthly</td>
</tr>
</tbody>
</table>

07/05/2023
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).
Kansas offers families a choice between an Inpatient psychiatric facility for individuals less than 21 years of age as provided in 42CFR 440.160 and Home Community Based Services (HCBS). Families shall be informed of any realistic alternative available under the waiver, and given the choice of either inpatient psychiatric facility or home and community-based services (HCBS) [42 CFR 441.302(d)]. Due to the age, numbers served and targeted population for the state of Kansas Autism waiver, if a family should choose an Inpatient psychiatric facility rather than HCBS, Kansas, through the managed care delivery model, enters into a contract with an out of state provider to provide services for that child.

After the child is determined to be eligible for the HCBS/Autism waiver services, the child/family receives:

1) A copy of the completed form(s) used to document freedom of choice and to offer a fair hearing;

2) A description of the contracted functional assessors procedure(s) for informing eligible children (or their legal representatives) of the feasible alternatives available under the waiver;

3) A description of the State’s procedures for allowing participants to choose either institutional or home and community based services; and

4) A description of how the participant (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

5) The Freedom of Choice form is signed at the time the Level of Care assessment is completed.

**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.

The Family Choice Document (freedom of choice) form, Rights and Responsibilities, and Request for a Fair Hearing is maintained in the child's case file at the state assessing entity per K.A.R 30-60-57 for a minimum of three years. A child's/family members signature on the Family Choice Document indicates and ensures they have been informed of the options available.

**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 participants whose primary language is not English, 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 to individuals who have English as a second language or non-primary language. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with non-English speaking participants, states are required to capture language preference information. This information is captured in the demographic section of the Vineland instrument.

The State of Kansas defines prevalent non-English languages as languages spoken by a significant number of potential enrollees and participants who are already enrolled. Potential enrollee and enrolled participant materials will be translated into the prevalent non-English language required by the participant.

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 participant in his/her spoken language. (K.A.R. 30-60-15).
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:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Respite Care</td>
</tr>
<tr>
<td>Supports for Participant Direction</td>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Family Adjustment Counseling</td>
</tr>
<tr>
<td>Other Service</td>
<td>Parent Support and Training (peer to peer) Provider</td>
</tr>
</tbody>
</table>

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):
- Respite Care

HCBS Taxonomy:

**Category 1:**

- Sub-Category 1:
  - 09 Caregiver Support
  - 09011 respite, out-of-home

**Category 2:**

- Sub-Category 2:
  - 09 Caregiver Support
  - 09012 respite, in-home

**Category 3:**

- Sub-Category 3:

**Service Definition (Scope):**

**Category 4:**

- Sub-Category 4:
Respite Care provides temporary direct care and supervision for the child. The primary purpose is relief to families/caregivers of a child with an autism spectrum disorder. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing respite care, and include support in the home, after school, or at night.

Transportation to and from school/medical appointments/ or other community based activities, and/or any combination of the above is included in the rate paid to providers of this services.

Federal financial participation (FFP) is not claimed for the cost of room and board.

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

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

1) Respite Care services are available to participants who have a family member who serves as the primary care giver who is not paid to provide any HCBS/ Autism service for the child.

2) Respite care may not be provided by a parent of the child.

3) Respite Care cannot be provided to an individual who is an inpatient of a hospital or State Mental Hospital when the inpatient facility is billing Medicaid, Medicare and/ or private insurance.

4) Respite Services are subject to prior approval.

5) Respite care is provided in planned or emergency segments and may include payment during the individuals sleep time

6) Respite has a limit to 168 hours per calendar year. However, families may request additional hours of Respite care by contacting their MCO care coordinator.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Individual</td>
<td>Self Directed Respite</td>
</tr>
<tr>
<td>Agency</td>
<td>Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)</td>
</tr>
<tr>
<td>Agency</td>
<td>Financial Management Services</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

[ ] Individual
Provider Type:

Self Directed Respite

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family’s qualifications,

Must reside outside of child’s home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS Provider

Frequency of Verification:

Every 2 years by FMS Provider background checks are required on hired self-directed employees of participants.
Provider Category: Agency
Provider Type: Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)

Provider Qualifications

License (specify):

Community Service Provider will be licensed by KDADS,
Community Mental Health Center will be licensed under K.A.R. 30-60-1

Certificate (specify):

Other Standard (specify):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

High School Diploma or equivalent,
Eighteen years of age or older,
Must meet family’s qualifications,
Must reside outside of child’s home,
Completion of the state approved training curriculum, and
Medicaid Enrolled Provider
MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services
<table>
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<th>Service Type: Statutory Service</th>
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<tr>
<td>Provider Type:</td>
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<tr>
<td>Financial Management Services</td>
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</table>

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

All FMS providers must meet established provider qualifications prior to being contracted and credentialed with a KanCare Managed Care Organization (MCO) and providing FMS services. Qualified providers must have a valid FMS Agreement with KDADS, Medicaid Provider Agreement with the Kansas Medical Assistance Program (KMAP), and meet all other provider qualifications as outlined in the agreement, the applicable HCBS Program, and in the FMS policy.

**Other Standard (specify):**
All FMS providers must meet established provider qualifications prior to being contracted and credentialed with a KanCare Managed Care Organization (MCO) and providing FMS services. Qualified providers must have a valid FMS Agreement with KDADS, Medicaid Provider Agreement with the Kansas Medical Assistance Program (KMAP), and meet all other provider qualifications as outlined in the agreement, the applicable HCBS Program, and in this policy.

a. Provider Qualifications

To be considered a qualified FMS provider, the provider must meet Federal, KDADS and MCO requirements prior to providing FMS for participant-directed services. To enroll as an FMS provider for HCBS Programs, each FMS must meet the following provider qualifications prior to providing FMS for participants directing their care under an HCBS Program operated by KDADS:

1. Valid KDADS FMS Agreement
2. Kansas Medicaid Provider Agreement and valid KMAP Number
3. Registration and good standing with the Secretary of State’s office, if required
4. Community Developmental Disability Organization’s (CDDO) Affiliate Agreement, if serving participant’s on the HCBS-IDD Program
5. Proof of Insurance – liability, worker’s compensation, unemployment, and others
6. Financial solvency, including accepted GAAP or compliance audit, as required
8. Federal Employer Identification Number as employer agent in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70

b. Provider Competencies

FMS Providers must meet Federal, state and HCBS Program requirements. To serve self-directing participants of HCBS programs, an FMS should be able to meet the following expectations:

1. Be an enrolled provider in the Kansas Medical Assistance Program;
2. Meet the FMS provider qualifications as outlined in this document;
3. Operate in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70 and any other future revenue procedures, notices or publication promulgated by the IRS in the future;
4. Operate in compliance with the Standards as outlined in this document and maintain documentation to support its compliance with these standards;
5. Demonstrate the capacity and continued capacity to perform the required responsibilities as identified in the Compliance Audit, onsite review, or FMS KDADS rev 12.21.15 eff. 4.10.15 6.5.C.2-2
6. Financial Services Manual (FMS) Participant-Directed Services and Supports
7. Support the principles and philosophy of KDADS’s home and community-based programs as described in Section II.3 above;
8. Have management and staff that are knowledgeable and have experience in providing FMS and working with persons with disabilities and chronic conditions;
9. Comply with Medicaid requirements related to collecting client obligation and applying third party liability for all participants receiving HCBS Program services and supports;
10. Maintain books, records, documents, and other evidence of expenditures in with generally accepted accounting principles (GAAP);
11. Make all books, records and documents available for inspection by the KDADS, the MCOs, or other state and federal authorities, as applicable, and without prior notice;
12. Report all suspected cases of neglect, abuse, and exploitation of participants applying for or receiving waiver services within 24 hours of awareness to the appropriate authorities;
13. Comply with all relevant federal, state and local laws related to payroll, taxes, withholding, reporting, insurance, and related criteria;
14. Demonstrate its capacity to develop and implement an information system to manage FMS-related records and files effectively;
15. Conduct FMS activities separate and distinct from the agency-directed function if the organization is a direct care service provider and/or a supports coordination/care management provider for the KDADS;
16. Secure FMS provider personnel, office space, documentation and records to ensure confidentiality...
and HIPAA compliance of all FMS records;
17. Report payroll, tax and other administrative duties to the participant on a regular basis to ensure participant control, choice and self-direction in participant-directed services;
18. Demonstrate the ability to monitor, identify and report instances of potential fraud, waste, and abuse to the appropriate authorities and ensure correct claims billing for HCBS Program participants directing their care;
19. Utilize AuthentiCare® KS for authorizations, billing, claims, reporting, and tracking direct service workers;
20. Demonstrate knowledge of and ability to stay current with federal, state and local tax, labor, workers’ compensation insurance and program regulations related to the KDADS’s HCBS Programs, Medicaid, the delivery of FMS, and household employers and domestic service workers; and
21. Demonstrate the ability to select, contract with and oversee the performance of a reporting agent effectively, if it so desires and as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

KanCare MCO's, KDADS and KDHE.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1: 
12 Services Supporting Self-Direction

Sub-Category 1:
12010 financial management services in support of self-direction

Category 2: 
12 Services Supporting Self-Direction

Sub-Category 2:
12020 information and assistance in support of self-direction

Category 3:

Sub-Category 3:
Service Definition (Scope):

Category 4: Sub-Category 4:
Respite Care services can be agency directed or self directed. Self directed is an added service to this waiver to offer increased flexibility for participants in finding caregivers. FMS is a needed service under the self directed option. The FMS provider is to perform background checks, assist families in finding and training attendants and provider other information and assistance. FMS is paid out at 1 unit per month.

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

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

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

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

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
FMS is limited to one unit per month. FMS can only be billed for months that respite is billed and used. Every FMS provider that credentials with the MCO is required to complete a readiness review to assure they are qualified to provide these services.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Enrolled Medicaid Provider of Financial Management Services</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:

Enrolled Medicaid Provider of Financial Management Services

Provider Qualifications

License (specify):

Not applicable.

Certificate (specify):

Not applicable.

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

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

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

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services
C-1/C-3: Service Specification

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

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

**Service Title:**

Family Adjustment Counseling

**HCBS Taxonomy:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
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<tbody>
<tr>
<td>10 Other Mental Health and Behavioral Services</td>
<td>10060 counseling</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category 3:</th>
<th>Sub-Category 3:</th>
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**Service Definition (Scope):**

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
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</thead>
</table>
Counseling can be provided to the family members of a child with an autism spectrum disorder in order to guide and help them cope with the child’s illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing continuous, daily care required by the child with an autism spectrum disorder. Enabling the family to manage this stress improves the likelihood that the child with the disorder will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Family Adjustment Counseling offers the family a mechanism for expressing emotions associated with the comprehension of the disorder and asking questions about the disorder in a safe and supporting environment. When acceptance of the disorder can be achieved the family is prepared to support the child on an ongoing basis. The service is provided by a Licensed Mental Health Professional (LMHP).

For the purposes of this service, "family" is defined as unpaid persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, or grandparents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized person centered service plan.

Family Adjustment Counseling does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost. Family Adjustment Counseling provides the family the ability to meet with a counselor who is a Licensed Mental Health Professional to assist in coping with the child’s illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing, continuous, and daily care required by the child with an ASD. This model allows the family to meet with a counselor without the child present. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant’s functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of supports through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication. Text messaging and e-mailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

Direct support can be provided through the virtual delivery of the service when all of the following requirements are met:

a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.

b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.

c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;

i. Participants must have an informed choice between in person or the virtual delivery of the service;

ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and

iii. Participants must affirmatively choose virtual delivery of the service over in-person supports.

e. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant’s Person-Centered Plan;

f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.

g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant’s protected health information.

h. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant’s home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.

j. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.

k. The provider must develop, maintain, and enforce written policies, approved by the state, which address:
   i. Identifying whether the participant’s needs, including health and safety, can be addressed safely via virtual delivery of the service.
   ii. How the provider will ensure the participant’s rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
   iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
   iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals’ right to privacy.

Instances, Instructions, and Limitations:

Instances
Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations
• The program participant’s person-centered service plan must indicate the use of the virtual delivery of the service.
• The managed care organization must document the frequency of the virtual delivery of the service.
• Virtual delivery of a service shall be provided in real-time, not via a recording.
• When virtual delivery of the service is provided, the provider shall only render the service or support on a one-on-one/individualized basis.
• The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider’s virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider’s operating costs.

Technology and Devices
• Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
• HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
• The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant’s Choice
• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
• The virtual delivery of the service shall be provided in the participant’s preferred setting.
• The participant’s choice for virtual delivery of a service shall be documented and included in their service plan.
• The participant shall be able to rescind their choice of virtual delivery of a service at any time.
• When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant’s service plan reflects the participant’s choice change.
• The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

Training Requirement
• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
• The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

Units and Delivery
• One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same)
when provided through virtual delivery of a service and shall be reimbursed equivalently.
  • The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
  • The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
  • If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
  • The participant shall have total control of the device, including turning it off or on.
  • It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

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

Family Adjustment Counseling is limited to 15 hours per calendar year.

Families may request more hours from their MCO if needed.

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child’s person-centered service plan.

Group setting cannot consist of more than 3 families.

The group membership requirement for Family Adjustment Counseling is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting.

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPAA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. The State intends for the family to receive in-person services if they desire. The telehealth option is to be used as a secondary option if desired by the family.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>Individual</td>
<td>Family Adjustment Counseling Provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Provider Category: Family Adjustment Counseling

Agency
Provider Type:

Community Mental Health Center

Provider Qualifications

License (specify):

- Community Mental Health Center must operate and function within regulatory guidelines set forth in K.A.R. 30-60-1

Certificate (specify):

Other Standard (specify):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Adjustment Counseling

Provider Category:

Individual

Provider Type:

Family Adjustment Counseling Provider

Provider Qualifications

License (specify):
a Licensed Mental Health Professional (LMHP) must hold a current license to practice in the state of
Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R. 28-5-564

Certificate (specify):

Other Standard (specify):

Adherence to KDADS training and professional development requirements; maintenance of clear
background as evidenced through background checks of: Kansas Bureau of Investigation (KBI), Adult
Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle
screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of
the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970
& 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Parent Support and Training (peer to peer) Provider

HCBS Taxonomy:
Service Definition (Scope):

Category 1: 09 Caregiver Support
Sub-Category 1: 09020 caregiver counseling and/or training

Category 2:
Sub-Category 2:

Category 3:
Sub-Category 3:

Category 4:
Sub-Category 4:
Parent Support and Training is designed to provide the training and support necessary to ensure engagement and active participation of the family in the treatment process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Support and Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family with the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their autism spectrum disorder and treatment; and development and enhancement of the family’s specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

For the purposes of this service, "family" is defined as persons who live with or provide care to a child served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's person-centered service plan.

1. Support, coaching and training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member.
2. This involves helping the families identify and use healthy coping strategies to decrease caregiver strain, improve relationships with family, peers and community members and increase social supports;
3. Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the participant in relation to their mental illness and treatment;
4. Development and enhancement of the families’ specific problem-solving skills, coping mechanisms, and strategies for the participant's symptom/behavior management;
5. Assist the family in understanding various requirements of the waiver or grant process, such as the crisis plan and plan of care process;
6. Educational information and understanding on the participant’s medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the participant with mental illness while living in the community; provide information on supportive resources in the community;
7. Service must be intended to achieve the goals and/or objectives identified in the participant's Person-Centered Service Plan.

Parent Support and Training does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost. Providers are required to be licensed with the Community Mental Health Center and they contract directly with the Managed Care Organizations.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant’s functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of supports through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication. Text messaging and e-mailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

Direct support can be provided through the virtual delivery of the service when all of the following requirements are met:

a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
   i. Participants must have an informed choice between in person or the virtual delivery of the service;
   ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
   iii. Participants must affirmatively choose virtual delivery of the service over in-person supports.
e. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant’s Person-Centered Plan;

f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.

g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant’s protected health information.

h. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:

i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant’s home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.

i. The virtual supports meets all federal and State requirements, policies, guidance, and regulations.

j. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.

k. The provider must develop, maintain, and enforce written policies, approved by the state, which address:

i. Identifying whether the participant’s needs, including health and safety, can be addressed safely via virtual delivery of the service.

ii. How the provider will ensure the participant’s rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.

iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and

iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals’ right to privacy.

Instances, Instructions, and Limitations:

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

• The program participant’s person-centered service plan must indicate the use of the virtual delivery of the service.

• The managed care organization must document the frequency of the virtual delivery of the service.

• Virtual delivery of a service shall be provided in real-time, not via a recording.

• When virtual delivery of the service is provided, the provider shall only render the service or support on a one-on-one/individualized basis.

• The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider’s virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider’s operating costs.

Technology and Devices

• Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.

• HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.

• The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant’s Choice

• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.

• The virtual delivery of the service shall be provided in the participant’s preferred setting.

• The participant’s choice for virtual delivery of a service shall be documented and included in their service plan.

• The participant shall be able to rescind their choice of virtual delivery of a service at any time.

• When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that
the participant’s service plan reflects the participant’s choice change.

• The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

Training Requirement

• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).

• The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

Units and Delivery

• One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.

• The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.

• The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.

• If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.

• The participant shall have total control of the device, including turning it off or on.

• It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.
e. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of a service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
h. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.
j. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
k. The provider must develop, maintain, and enforce written policies, approved by the state, which address:
i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances, Instructions, and Limitations:

Instances
Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations
• The program participant’s person-centered service plan must indicate the use of the virtual delivery of the service.
• The managed care organization must document the frequency of the virtual delivery of the service.
• Virtual delivery of a service shall be provided in real-time, not via a recording.
• When virtual delivery of the service is provided, the provider shall only render the service or support on a one-on-one/individualized basis.
• The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider’s virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices
• Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
• HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
• The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant’s Choice
• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
• The virtual delivery of the service shall be provided in the participant’s preferred setting.
• The participant’s choice for virtual delivery of a service shall be documented and included in their service plan.
• The participant shall be able to rescind their choice of virtual delivery of a service at any time.
• When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that
the participant’s service plan reflects the participant’s choice change.

- The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

Training Requirement
- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

Units and Delivery
- One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.
- The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
- The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
- If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
- The participant shall have total control of the device, including turning it off or on.
- It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

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

Parent Support and Training is limited to 30 hours per calendar year.

Families may request more hours from their MCO if needed.”

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child’s person-centered service plan.

Group settings cannot consist of more than 3 families.

The group membership requirement for Parent Support is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting.

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. The state requires three years of experience working with a child diagnosed with ASD.

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:
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Support and Training (peer to peer) Provider

Provider Category:
Agency

Provider Type:
Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)

Provider Qualifications

License (specify):

Community Service Providers are licensed by KDADS
Community Mental Health Center will be licensed under K.A.R. 30-60-1

All licensed agencies that are on file with the Secretary of State’s office that are or can become Medicaid enrolled, and employ individuals that meet the qualifications of a parent support and training provider. The types of licensed agencies that can enroll in Medicaid to provide HCBS services are listed here: https://www.kmap-state-ks.us/Documents/Content/Checklists/HCBS.PDF.

Certificate (specify):

Other Standard (specify):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

*High School Diploma or equivalent
*Twenty-one years of age or older
*Completion of parent support training or other approved training curriculum.
*Must have three years of direct care experience with a child with an autism spectrum disorder, Or be the parent of a child with an autism spectrum disorder.
*Medicaid Enrolled provider and MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

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

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**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Parent Support and Training (peer to peer) Provider

**Provider Category:**  
[Individual]

**Provider Type:** Parent Support Provider

**Provider Qualifications**

- **License (specify):**

- **Certificate (specify):**

- **Other Standard (specify):**
Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of: Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

* High School Diploma or equivalent
* Twenty-one years of age or older
* Completion of parent support training or other approved training curriculum.
* Must have three years of direct care experience with a child with an autism spectrum disorder, Or be the parent of a child with an autism spectrum disorder
* Medicaid Enrolled Provider
* MCO contracted provider

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

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

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**Appendix C: Participant Services**

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

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

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

*Check each that applies:*

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
As an administrative activity. Complete item C-1-c.

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

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

Appendix C: Participant Services

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

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

- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

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

The contractor / sub contractor and /or provider must complete a Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and motor vehicle screen upon the hiring of the following providers of services:

- Eligibility Determination (Functional Eligibility Specialist)
- Respite Care Provider
- Parent Support Specialist Provider
- Family Adjustment Counseling Provider

The contractor / sub contractor and /or provider must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

A single provider must provide the above documentation along with qualifications to the MCO and receive prior authorization before the delivery of services.

The completion of all required background checks and screenings are the responsibility of the potential waiver provider. All background checks/screens must be completed and submitted with provider enrollment applications. If a provider is identified to have an offense on the Prohibited Offenses list, there is no exception. Any potential service provider found to be convicted of a Prohibited Offense will not be enrolled or credentialed as a waiver provider.

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

- No. The state does not conduct abuse registry screening.
Yes. The state maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The contractor / sub contactor and /or provider must check all individuals against the Kansas Department for Children and Families (DCF) child abuse, adult abuse and nurses aid registries. DCF Children and Adults Services maintain the registries for all confirmed perpetrators.

-Functional Eligibility Determination (Eligibility Specialist)
-Respite Care Provider
-Parent Support Specialist Provider
-Family Adjustment Counseling Provider

The contractor / sub contactors and /or providers must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6.

All background checks/screens are the responsibility of the potential waiver provider. All results must be submitted with all other required documentation at the time the application is submitted. There are no exceptions for those who have been identified with an offense listed on the Prohibited Offenses list. Any potential service provider found to be convicted of a Prohibited Offense will not be enrolled or credentialed as a waiver provider.

Appendix C: Participant Services
C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.
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.

- 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:
Participants of HCBS-Autism 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, Kansas Department of Health and Environment, (KDHE), for the Kansas Medical Assistance Program; and also must contract with, and meet the contracting terms of, the KanCare MCOs.

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 the providers that support HCBS waiver members have had focused discussions with State staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to quality 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 has been made available via State and MCO websites.

All providers submit the required application, background check/screening, and required program specific documentation to the Kansas Medical Assistance Program (KMAP) at the time of enrollment. All applications are reviewed and processed in the order that they are received, usually within forty-five (45) days of application submission date provided a complete application is received.

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 record reviews

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

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- [ ] 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

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

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Sampling Approach (check each that applies):

- [ ] 100% Review
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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency.

### 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 and percent of 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

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Application for 1915(c) HCBS Waiver: Draft KS.004.03.07 - Jan 01, 2024
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KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency

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

\[
N = \text{Number of new non-licensed/non-certified providers}
\]
\[
D = \text{Number of all new non-licensed/non-certified providers}
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Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Managed Care Organization (MCO) reports and record reviews

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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 Numerator:
Number of providers that meet training requirements Denominator: Number of active providers

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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.

KanCare MCOs are required to complete ongoing monitoring to ensure that their contracted providers meet all MCO credentialing and State Medicaid enrollments standards. The State completes MCO record reviews at least annually to ensure that all providers meet MCO credentialing and State enrollment standards.

The State completes record reviews with the MCOs to ensure that all MCO credentialed waiver providers meet the state Medicaid enrollment requirements. The State currently requires all Medicaid enrolled/MCO contracted providers to complete state approved training modules prior to delivering services. In the event that the training is not accessible at the time of enrollment providers are required to complete the state approved training modules within six (6) months of becoming an enrolled Medicaid approved provider. If the required training is not completed Medicaid enrollment/MCO contract is terminated.

### 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 the interagency monitoring team.

Data analysis is completed and remediated for any assurance or sub-assurance less than 100%. KDADS staff will notify the MCO of areas below 100% with details of each finding. KDADS staff will notify the MCO if any findings are below 87%, those that fall below 87% are required to also include a quality improvement project. The MCO will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.

Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.

Findings or concerns on a specific case identified through the review by Quality Management System (QMS) will be entered in Quality Review Tracker (QRT). Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

ii. Remediation Data Aggregation

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

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| ☐ 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.
The purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. Therefore, based on the type and scope of services, the Autism Waiver services is limited to four.

The four year limit applies to all services offered under this program. Autism waiver service limits have changed as they were once limited to three years with a request for a 1 yr extension. Waiver limits were designed based on research available at the time of program inception, stakeholder input and available funding for overall program administration.

Participants are provided information about the program at the time of initial program eligibility determination and notified of limitations by the MCO at the first assessment. Following level of care determination, the MCO is responsible for informing the participant of the Autism waiver program and service limitations. Program and specific service limitations are provided in the Autism waiver manual and made available to the public on KDADS, KDHE, KanCare MCO and Kansas Medical Assistance Program (KMAP) websites.

The MCO may adjust the limitation based on the waiver participant’s health or welfare needs or other factors documented in the participants Service Plan. Both, the State and the MCOs, have appeal processes in place to ensure that waiver participants may appeal adverse actions. Details on the appeals/grievances processes are captured in Appendix F of the waiver.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

The State submitted a proposed Statewide Transition Plan pending CMS approval. see Main section, attachment #2

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 (Service Plan)

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

- Registered nurse, licensed to practice in the state
- Licensed practical or vocational nurse, acting within the scope of practice under state law
- Licensed physician (M.D. or D.O)
- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:
Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The Managed Care Organization assigns a Care Coordinator for each participant. The Care Coordinator is responsible for organizing the Person Centered Planning Team meetings and assuring the Service Plan includes input from the participant and their family.

The CONTRACTOR(S) service coordinators shall have experience that is appropriate to the Member’s health care needs and shall perform activities within their scope of practice in accordance with applicable licensing/credentialing rules. The CONTRACTOR(S) has the flexibility to determine the service coordinator qualifications for populations not specifically listed here. Service coordinators working with specific populations shall have specific qualifications. CONTRACTOR(S) and community service coordinators serving Members who are in multiple population groups, such as youth in foster care who are enrolled on a HCBS Waiver, shall be assigned service coordinator most appropriate for the Member’s needs and have experience working with the populations to be served.

At minimum qualifications shall include:

A. For Members with a LTSS need, CONTRACTOR(S) and community service coordinators shall:
   1. Have at least a bachelor’s degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN).
   2. Have at least one (1) year of experience working with individuals with long-term care needs, and if working with a specific Waiver population (e.g. IDD, TBI or Frail Elderly [FE]), at least one (1) years’ experience working directly with that population. Fulltime experience in the field of developmental disabilities services may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college for service coordinators working with individuals with IDD. Additionally, community service coordinators providing services to individuals with IDD must meet qualifications described in K.A.R. 30-63-32-Article 63.
   3. Comply with additional qualifications as described in the State’s HCBS Waivers included in Attachment C of this RFP.

B. For Members with a Behavioral Health need, CONTRACTOR(S) and community service coordinators shall:
   1. Have at least a bachelor’s degree in social work, nursing, rehabilitation, psychology or related health and human services area, or be a RN.
   2. Have at least one (1) year of experience working with individuals with Behavioral Health needs and receive training in trauma informed care.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Select one:

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

According to K.A.R. 30-5-305 qualified staff and assessment providers shall conduct an assessment prior to the implementation of any HCBS services.

When the Functional Eligibility Specialist has determined a child likely to require the level of care provided in inpatient psychiatric facility for individuals under 21 years of age, the child/family or his/her legal representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community based services [42 CFR 441.302 (d), and permitted to choose between them. 

Child/family has access to the following:

- A copy of the forms(s) used to document freedom of choice and to offer a fair hearing
- The HCBS/Autism Waiver Participant Rights and Responsibilities which, among other Rights and Responsibilities, lists the right to services which are provided to persons in their category of eligibility in accordance with the Medicaid State Plan, based on the availability of services and fiscal limitations.

b. Once the child/family has received the above mention information and would like to receive HCBS/Autism waiver services the child/family is then given a provider list in which the family chooses their provider(s). The child/family, unless a guardian is in place, have the right to determine who is included in the process, and which service providers to use.

The Managed Care Organization assigns a Care Coordinator for each participant. The Care Coordinator is responsible for organizing the Person Centered Planning Team meetings and assuring the Service Plan includes input from the participant and their family.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

State Response: Needs Assessment(s) completed by the MCO within 6 months, which must address:

- Physical, and
- Behavioral, and
- Functional

Each of these areas must be addressed in the Person-Centered Service Plan.

b) All applicants for program services must undergo a Vineland 3 to determine functional eligibility for the Autism waiver. The Vineland 3 is utilized to determine the level of care (LOC) eligibility for the Autism waiver. The State’s functional eligibility contractor conducts an assessment of the individual within the time frame specified in the contract, unless a different time frame is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant within six months and must address physical, behavioral and functional needs in the Person-Centered Service Plan that identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant will complete a Participant Interest Inventory (PII). The PII is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Service Plan meeting and will use the PII to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

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

d) Through the various assessments and Service Plan related documents described in b) above, the participant’s goals, needs and preferences are at the forefront of developing their Service Plan. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.
e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS’ Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, upon MCO notification or awareness of necessitating circumstances. Responsibilities are designated by the MCO Care Coordinator during the Person Centered Service Plan meeting. These assignments are documented in the Service Plan. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. Each service provider who will participate in the delivery of services shall sign a statement of understanding and consent to deliver the applicable services included in the Person-Centered Service Plan. The MCO Care Coordinator would need to include all services the child needs to access on the Person Centered Service Plan. This will include State plan services as well as waiver services.

1. The MCO shall coordinate obtaining provider signatures.
   b) Provider signature does not constitute approval or denial of the Person-Centered Service Plan. Provider signatures indicate an understanding of the Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established in the Person-Centered Service Plan.
   2. The participant may request that their primary or specialty care providers sign their plan, if this request is made, the MCO Care Coordinator is responsible to obtain signature from these providers.
      a) In the event the provider originally selected refuses to sign a statement of agreement, the MCO Care Coordinator shall provide education to the participant that services on the plan cannot be provided by a Provider who is unwilling to sign the plan.
      b) The MCO Care Coordinator shall obtain another provider choice from the individual.
   3. In the event the only willing provider of HCBS services refuses to sign the Person-Centered Service Plan, the MCO must obtain signed documentation from the party that they refuse to sign the plan and the MCO Care Coordinator shall notify the applicable HCBS Program Manager, in writing, of this refusal. MCOs shall proceed with services for providers who have signed the Person-Centered Service Plan.
   4. When interim changes are made to a participant’s Person-Centered Service Plan that MCO Care Coordinator must also obtain a signature from the impacted service providers.
   5. Providers who fail to sign a statement of agreement will not be paid for services provided prior to MCO receipt of a signed statement from the provider.

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

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

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

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

The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument, which identifies potential risk factors. The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers. The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):
The MCO and the child/family develop a Person Centered Service Plan. This plan is then submitted to the contracted MCO of choice for the plan's approval.

The MCO is responsible for maintaining a copy of an electronic or paper Person Centered Service Plan in the child’s file.

Engagement of the interagency monitoring team, brings 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 on a quarterly basis.

The State Operating Agency Quality Management Staff (QMS) conducts routine oversight of service plans including: On-site reviews are conducted, at a minimum, annually. The State Operating Agency QMS conduct ongoing reviews based upon a statistically valid random sample of service plans, at a minimum quarterly. Critical components of the SSMA and Operating Agency’s role in service plan development include:

1. Engagement of the interagency monitoring team, which meets quarterly and brings together agency 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.

2. Continuance of the Long Term Committee where the Operating Agency reports quality assurance and programmatic activities to SSMA for oversight and collaboration.

KDADS conducts quarterly reviews of the MCO service plans by the KDADS Quality Assurance team. KDADS Quality Assurance Team follows a protocol to evaluate each service plan. The KDADS Program Manager reviews these results as well as the KDHE Waiver Managers. The MCO’s are assigned to implement approved Quality Improvement Plans to address any and all deficiencies. We are looking at a sample that meets specifications as indicated in the waiver.

The sample review using a 95% confidence level review. These reviews are conducted quarterly. KDADS Quality Assurance Team follows the protocol established for performance measure reviews. KDADS Program Manager and KDHE Waiver Managers review for accuracy. KDADS assigns approved Quality Improvement Plans to the MCO's in cases where they do not meet the threshold for the performance measures.

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
The Eligibility Specialist maintains copies of the original FEI, freedom of choice forms, and the Rights and Responsibilities forms.

The KanCare MCOs maintain the copies of the above mentioned information as well as any additional forms such as; the child/family strengthens and needs assessment, individualized behavioral program and Service Plan, detail progress notes, etc., In the child’s case file.

Copies are maintained for a minimum period of 3 years as required by 45 CFR 74.53

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 three KanCare contracting managed care organizations are responsible for monitoring the implementation of Service Plans that were developed as a partnership between the participant and the MCO and for ensuring the health and welfare of the participant with input from the Autism 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 Plans 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;
- Services meet participant's needs;
- Liabilities with self-direction (if applicable)/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 Plans 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 plans of care.

In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the participant.
- Choice is documented.
- The Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually.

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 requiring remediation are reported to the MCO and waiver provider for prompt follow-up and feedback. Related information is reported to the Autism 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.

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.

The monitoring methods are a desk review of the Service Plans provided by the MCO's as assigned during quarterly reviews. The sample is statistically significant based off of approved waiver standards. Currently there is one performance measure where data is collected based off returned member survey results. The survey includes questions regarding current services and the individuals/guardians experience with HCBS services and the waiver. KDADS assigns remediation to each MCO in the form of a request for a Quality Improvement Plan for each performance measure they do not meet the 87% threshold. KDADS staff follows up with a QIP meeting for each MCO to approve or amend QIP's submitted by the MCO's. KDADS then follows up to review progress by each MCO's quarterly review scores to evaluate improvement or adjust the QIP as necessary to meet the performance measure.

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:
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 all of each participant's health and safety risk factors

\[ N = \text{Number of waiver participants whose service plans address all of each participant's health and safety risk factors} \]

\[ D = \text{Number of waiver participants whose service plans were reviewed} \]

**Data Source (Select one):**
Other
If ‘Other’ is selected, specify:

**Record reviews**

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KanCare Managed Care Organizations (MCOs) | Proportionate by MCO
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### Data Aggregation and Analysis:

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

Performance Measure:

Number and percent of waiver participants whose service plans address participants' goals

- **Numerator:** Number of waiver participants whose service plans address participants' goals
- **Denominator:** Number of service plans due to be updated for annual redetermination that were reviewed.

**Data Source** (Select one):

- Other

07/05/2023
If ‘Other’ is selected, specify:

**Record reviews**

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| ☐ Sub-State Entity | ☑ Quarterly | ☑ Representative Sample  
Confidence Interval = 95% |
| ☑ Other  
Specify: KanCare Managed Care Organizations | ☐ Annually | ☑ Stratified  
Describe Group: Proportionate by MCO |
| ☑ Other  
Specify:  
Continuously and Ongoing | ☐ Other  
Specify: | |
| ☐ Other  
Specify: | | |

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Specify: | ☑ Annually |
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Performance Measure:
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment Numerator: Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

Record reviews

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<td>☐ Continuously and Ongoing</td>
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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):
- Record reviews, off-site

If ‘Other’ is selected, specify:

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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):
Record reviews, off-site
If ‘Other’ is selected, specify:

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### 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):

**Record reviews, on-site**

If 'Other' is selected, specify:

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Application for 1915(c) HCBS Waiver: Draft KS.004.03.07 - Jan 01, 2024

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07/05/2023
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**Sub-assurance:** Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

**Performance Measures**

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

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

**Performance Measure:**
Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan

\[
N = \text{Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan}
\]

\[
D = \text{Number of waiver participants whose service plans were reviewed}
\]

Data Source (Select one):

Other

If ’Other’ is selected, specify:

Record reviews and Electronic Visit Verification (EVV) reports, if applicable
Responsible Party for data collection/generation (check each that applies):

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KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency

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

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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 services

\[
\text{N} = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver services} \\
\text{D} = \text{Number of waiver participants whose files are reviewed for documentation indicating a choice of waiver services}
\]

Data Source (Select one):

Other
If ‘Other’ is selected, specify:

Record reviews
Confidence Interval = 95%

- **Other**
  - Specify: KanCare Managed Care Organizations (MCOs)
- **Annually**
- **Stratified**
  - Describe Group: Proportionate by MCO
  - **Continuously and Ongoing**
  - **Other**
    - Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency
  - **Annually**
  - **Continuously and Ongoing**

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| ✔ Other
  - Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency | ☐ Annually |
| | ✔ Continuously and Ongoing |

Other Specify:
Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative
N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation

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

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Data Aggregation and Analysis:
### Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers

\[ N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver service providers} \]
\[ D = \text{Number of waiver participants whose files are reviewed for the documentation indicating a choice of waiver service providers} \]

### Data Source (Select one):
- Record reviews, off-site

If 'Other' is selected, specify:

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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 priority identification regarding all waiver assurances and minimum standards and 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 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 trended to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally. 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.

KDADS Quality Assurance field staff have file review protocol questions to assess whether service plans include waiver processes, such as:
- Providing Choice;
- Rights & Responsibilities;
- Notice Of Action for adverse actions, terminations, denials or change in service plans;
- Service plan include goals;
- Addresses health and safety risks and needs; and
- Participant involvement

If a case is found to have errors, the State would note that measure as not being met. An example of an error or non-compliant measure could include but may not limited to:
- Doesn’t appear the service plan adequately addressed the needs, or health or safety risks; or goals.
- No evidence (i.e., signature/date of consumer) the participant participated and was involved in the development of their service plan.

MCOs are required to monitor service plan development of contracted providers as part of their ongoing quality process. The State completes, at a minimum, annual record reviews for the Autism Waiver oversight to overall service plan development of MCOs and contracted providers.

### 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 of waiver performance standards as detected through on-site monitoring, survey results and other performance 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)**

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ State Medicaid Agency</td>
<td>☐ Weekly</td>
</tr>
</tbody>
</table>
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.
All participants of Autism waiver services have the opportunity to choose the MCO that will support them in overall service access and care management. The opportunity for participant direction (self-direction) is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100). Respite is the only service that can be participant directed on this waiver. This opportunity includes specific responsibilities required of the participant, including:

• Recruitment and selection of providers;
• Assignment of service provider hours within the limits of the authorized services;
• Complete an agreement with an enrolled Financial Management Services (FMS) provider;
• Referral of providers to the participant's chosen FMS provider;
• Provider orientation and training;
• Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
• Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
• Other monitoring of services; and
• Dismissal of the worker, if necessary.

b) Participants are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant’s Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant’s Person-Centered Service Plan. The MCO supports the participant who selects self-direction of services by monitoring services to ensure that they are provided by Respite services attendants in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider. FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

• Verification and processing of time worked and the provision of quality assurance;
• Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers’ compensation insurance requirements; making tax payments to appropriate tax authorities;
• Performance of fiscal accounting and expenditure reporting to the participant or participant’s representative and the state, as required.
• Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:

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

   - 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 participant must have a legal guardian to direct some or all of the services offered under participant-direction. Participant-direction is offered for the following services:

- Respite

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

a) Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about 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 benefits of self-direction;
- 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 Autism 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 state assessing agency), 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):

- [x] 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:

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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite Care</td>
<td>[x]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

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 Mental Health Center (CMHC) or Community Developmental Disabilities Organization (CDDO)
- 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:
Assist participant in verifying support worker citizenship status
☐ Collect and process timesheets of support workers
☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
☐ Other

Specify:

Supports furnished when the participant exercises budget authority:

☐ Maintain a separate account for each participant's participant-directed budget
☐ Track and report participant funds, disbursements and the balance of participant funds
☐ Process and pay invoices for goods and services approved in the service plan
☐ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
☐ Other services and supports

Specify:

Additional functions/activities:

☒ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
☒ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☐ Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
☐ Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
a) The State verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment).

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. 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):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Support and Training (peer to peer) Provider</td>
<td>❌</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>❌</td>
</tr>
<tr>
<td>Family Adjustment Counseling</td>
<td>❌</td>
</tr>
<tr>
<td>Respite Care</td>
<td>❌</td>
</tr>
</tbody>
</table>

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:

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.

Services in support of participant-direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. Two core service definitions are provided: (1) information and assistance in support of participant direction and (2) financial management services.

FMS providers assist the participant or participant’s representative by providing two distinct types of tasks: (1) administrative tasks and (2) information and assistance (I&A) tasks.

When a participant or participant’s representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:

• Choose and direct support services
• Choose and direct the workers who provide the services
• Perform the roles and responsibilities as employer
• Understand the roles and responsibilities of the FMS provider
• Receive initial and ongoing skills training as requested

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:
Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. 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 Respite coverage, as previously documented on the participant’s Service Plan, with the authorization for service;

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/CMHC; 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 participant's chosen MCO may discontinue self-direction and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:
1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if the health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS, and all training methods for the participant have been exhausted;
3. if the direct support worker has not adequately performed the services as outlined in the Person-Centered Service Plan (Service Plan);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or service provider has abused or misused self-direction including:
   • the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the needs assessment and/or POC;
   • the participant/representative has directed the service providers to provide, and the service providers has in fact provided paid comprehensive support or Enhanced Care Services beyond the scope of the service definition;
   • the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the Service Plan;
   • the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the service providers for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:
1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participant's attending physician or RN no longer authorizes the participant to self-direct his/her care; or
3. the participant/representative has committed a fraudulent act.

A timely Notice of Action (NOA) shall be sent to the participant prior to the effective date for termination of the participant's participation in the Self-Directed Care Option. The MCO coordinates to ensure there is not a lapse in service delivery.

The MCO works with the participant to maintain continuous attendant coverage as outlined and authorized on the participant's Service Plan. The MCO, through their care management and monitoring activities, works with the participant's choice of a non-self-directed agency to assure participant health and welfare during the transition period and beyond by communicating with both the participant and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the participant as to satisfaction with services.

Appendix E: Participant Direction of Services
E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Employer Authority Only</th>
<th>Budget Authority Only or Budget Authority in Combination with Employer Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>75</td>
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</tr>
<tr>
<td>Year 2</td>
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</tr>
<tr>
<td>Year 5</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant’s employer status under the waiver. Select one or both:

- Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/ Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Select one or more decision making authorities that participants exercise:

- Recruit staff
- Refer staff to agency for hiring (co-employer)
- Select staff from worker registry
- Hire staff common law employer
- Verify staff qualifications
- Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

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

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

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

- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to state limits
- Schedule staff
Orient and instruct staff in duties
Supervise staff
Evaluate staff performance
Verify time worked by staff and approve time sheets
Discharge staff (common law employer)
Discharge staff from providing services (co-employer)
Other

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the state's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.
ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Kansas has contracted with independent assessors to conduct level of care determinations (functional eligibility). Decisions made by the independent assessors are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors with their decision on the LOC determination/redetermination.

The Independent contractor conducts participant waiver assessments for current and potential participants. KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines program eligibility before KDHE determines financial eligibility.

Applicants/beneficiaries may file a fair hearing for an ineligible determination made by the contracting assessor agency.

KanCare Managed Care Organizations (MCOs) are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member.

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

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

An appeal can only occur under the following circumstances:
• If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
• Members will receive a Notice of Action in the mail if an Action has occurred.
• An Appeal is a request for a review of any of the above actions.
• To file an Appeal: Members or (a friend, an attorney, or anyone else on the member’s behalf can file an appeal).
• An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
• An appeal must be filed within 60 days calendar days plus 3 calendar days after the participant has received a Notice of Action.
• The appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant’s appeal will be resolve in 45 calendar days.

Fair Hearings

A member may request a Fair Hearing upon receiving a Notice of Action.

A Fair Hearing is a formal meeting where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all the facts and then hears motions, conduct hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge.
If the participant is not satisfied with the decision made on the appeal, the participant or their representative may ask for a fair hearing. The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision. The request be submitted in writing and mailed or faxed to:
Office of Administrative Hearings 1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

• HCBS eligibility decision: DHCF makes decisions regarding HCBS waiver eligibility. If an HCBS member loses eligibility for HCBS waiver services, DHCF sends the notice of action. The language regarding the member’s opportunity to request a fair hearing is in DHCF’s notice. Those notices are generated by KEES.
• HCBS service decision: The MCOs make decisions regarding HCBS waiver services. If an MCO reduces or terminates HCBS services, the MCOs issue the notice of adverse benefit determination (formerly called a notice of action). The language regarding a member’s opportunity to request a fair hearing is in that notice. The same information is also in each MCO’s Member Handbook. The notices are generated by each MCO’s notice generation system.

Participants have the right to benefits continuation of previously authorized services while a hearing is pending and can request such benefits as a part of their fair hearing request. All three MCOs will advise participants of their right to a State Fair Hearing. Participants have to finish their appeal with the MCO before requesting a State Fair hearing. The MCOs have the information regarding continuation of waiver services pending a hearing decision in their notices of adverse benefit determination. In Kansas, waiver beneficiaries are not required to request continuation. Following an MCO’s adverse benefit determination that reduces, suspends or terminates waiver services, the MCOs continue the waiver services during the 60-day appeal time period to give the beneficiary the opportunity to request an MCO appeal. If the waiver beneficiary requests an MCO appeal timely, the waiver services continued during the appeal time period are continued another 120 days. The beneficiary must request a hearing within the 120-day time period in order to have their services continued until the hearing decision.

For all KanCare MCOs:
In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs’ member web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

The State requires that all MCOs define an “action” pursuant to the KanCare contract and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event their Medicaid application is denied, MCOs issue a notice of adverse action under the following circumstances:

• The denial or limited authorization of a requested service, including the type or level of service;
• The reduction, suspension, or termination of a previously authorized service;
• The denial, in whole or in part, of payment for a service;
• The failure to provide services in a timely manner;
• The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
• For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

MCOs retain all Notices of Action in the participant's file.

**Appendix F: Participant-Rights**

**Appendix F-2: Additional Dispute Resolution Process**

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one:

- [ ] No. This Appendix does not apply
- [x] Yes. The state operates an additional dispute resolution process

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.
Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. Select one:

- No. This Appendix does not apply
- Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. Participants have the right to submit grievances or appeals to their assigned managed care organization. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), requires the managed care organizations to operate a member grievance and appeal system consistent with federal regulations and Attachment D of the State’s contract with CMS. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1. KanCare members are informed that filing an appeal with the MCO is a prerequisite for a Fair Hearing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are part of the State’s fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State’s fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. The fiscal agent team escalates any grievance prior to the 3-occurrence timeframe based on the severity of the grievance. Through the escalation processes the fiscal agent team contacts KDADS, KDHE or the appropriate local authority who have access to this information at any time to ensure the member’s safety and wellbeing.

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

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

Complaints are received in the state’s fiscal agent Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately.

Grievance Unit must make contact related to a grievance within 3 business days. If the situation is urgent, the grievance staff make contact immediately. The grievance is required to be resolved within 30 calendar days.

• HCBS eligibility decision: DHCF makes decisions regarding HCBS waiver eligibility. If an HCBS member loses eligibility for HCBS waiver services, DHCF sends the notice of action. The language regarding the member’s opportunity to request a fair hearing is in DHCF’s notice. Those notices are generated by KEES.

• HCBS service decision: The MCOs make decisions regarding HCBS waiver services. If an MCO reduces or terminates HCBS services, the MCOs issue the notice of adverse benefit determination (formerly called a notice of action). The language regarding a member’s opportunity to request a fair hearing is in that notice. The same information is also in each MCO’s Member Handbook. The notices are generated by each MCO’s notice generation system.

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).
Reporting KDADS defined adverse incident requirements:

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

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

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

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

Specifically, mandated reporters include: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF) and Substance Abuse Treatment Facilities. All other individuals who may witness a reportable event may voluntarily report it.

The timeframes within which critical incidents must be reported:

The timeframes within which critical incidents must be reported: KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days, of receiving the information. Outside of working hours, the reports shall be submitted to DCF on the first working day that the Kansas Department for Children and Families is in operation after the receipt of such information.

AIR is used to report adverse/critical incidents involving individuals receiving services by providers who are licensed by or contracted with KDADS including all HCBS waivers.

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident. MCOs and their providers are all required to submit AIR reports. MCOs are required to follow-up with KDADS on all substantiated ANE reports. All AIR reports are required to be submitted by direct entry into the KDADS web based AIR system.

Reporting entities/individuals may include (but are not limited to):

All KDADS licensed providers
KDADS Program Integrity staff members provide interactive trainings to entities that could potentially report incidents in the AIR System such as assessing entities, HCBS providers and the MCO's.

The MCO's are required to review the following steps and take the appropriate actions to ensure health and welfare of the waiver participant.

1. Back-up Plan
2. Behavior Support Plan
3. Behavioral Health Follow-up
4. Community Resource Referral
5. Complex Case Round
6. Corrective Action Plan
7. DPOA/Guardian Contact
8. Face-to-face visits
9. Increase Participant Engagement
10. Performance Improvement Plan
11. Integrated Person Centered Service Plan Change
12. Policy/Procedure Request
13. Potential Quality of care issue identified
14. Removal of Self-direction to Agency Directed Services
15. Safeguard Planning
16. TCM Contact

**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 or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual’s service plan. The information provided by the MCOs is consistent with the State's abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.
The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.

The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of the reporter becoming aware of the adverse incident by direct entry into the KDADS web-based AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP.

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

All reports of Abuse, Neglect, Exploitation and Fiduciary Abuse are reported to and investigated by DCF. Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual 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 Protective 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 automatically 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, PICS will determine the level of severity for each screened in adverse incident reported in AIRS, and will assign a level of severity. PICS will assign each incident with a Level 1 or Level 2 scoring. All abuse, neglect and exploitation reports are given a Level 2 priority. Within one business day of a determination of the severity level PICS will notify the participant’s MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and...
identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up. KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member’s Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP.

The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. Per PPS policy number 1521, reports assigned for Abuse/Neglect concerns shall be assigned with either a same day or 72-hour response time. Reports assigned as Non-Abuse/Neglect Family in Need of Assessment (NAN FINA) are assigned a response time per PPS policy number 1670.

PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. KDADS assigns the report to the participant’s managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

The entity that is responsible for conducting investigations and how investigations are conducted:

DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes. Per DCF PPS Policy and Procedure Manual 2500: The purpose of the case finding is to inform when abuse/neglect has occurred; and whether the identified perpetrator should be permitted to reside, work, or regularly volunteer in a child care facility. A case finding shall be completed for each assigned allegation associated with a child alleged or suspected to have been abused or neglected. The CPS specialist, in consultation with the PPS supervisor or designee, (See PPM 0140), shall make the finding decision based on information gathered by the CPS specialist or CPS investigator during investigatory activities. The decision is made by weighing the facts and circumstances learned during the investigation and assessment and applying the definition of abuse/neglect. The standard of evidence applied to all case finding decisions regarding abuse and neglect is preponderance of the evidence.

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 as outlined in the MOU with KDHE 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.
KDADS is the entity responsible for overseeing the operation of the (AIR) system as outlined in the inter-agency cooperative agreement. Kansas Department for Children and Families, Division of Child Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Child Protective Services maintains a database of all critical incidents/events and makes available the contents of the database to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an ongoing basis.

The KDADS Quality Program Manager is responsible for reviewing the incidences reported to AIR and assigning incident to appropriate KDADS field staff for discovery, follow up and remediation. The Quality Program Manager and the DCF Child Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS and the State Medicaid Agency.

The KDADS quality team is responsible for reviewing reported critical incidents and events. The data is collected and compiled, trended by waiver population so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement/remediation strategies to reduce future occurrence of critical incidents or events.

MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident. KDADS quality team reviews the MCO process, investigation and outcome of the AIR report. The quality team makes a determination if the MCO outcome is satisfactory and if not, will assign a corrective action plan and remediation as necessary.

MCO investigations shall be concluded in one of the following three findings:
Finding #1 - Doesn’t meet adverse incident definition – report reviewed by MCO and does not meet the Adverse Incident definitions as defined.
Finding #2 - MCO action required - Report was reviewed and MCO action is required. (Select all that apply)
1. Back-up Plan
2. Behavior Support Plan
3. Behavioral Health Follow-up
4. Community Resource Referral
5. Complex Case Round
6. Corrective Action Plan
7. DPOA/Guardian Contact
8. Face-to-face visits
9. Increase Participant Engagement
10. Performance Improvement Plan
11. Integrated Person Centered Service Plan Change
12. Policy/Procedure Request
13. Potential Quality of care issue identified
14. Removal of Self-direction to Agency Directed Services
15. Safeguard Planning
16. TCM Contact
Finding #3 - No MCO action required – Report was reviewed and no MCO action is required (e.g. death by natural causes, law enforcement/emergency medical involvement where no suspected ANE documented, etc.).
a. Use of Restraints. (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- The state does not permit or prohibits the use of restraints

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

The State has added 2 sub-assurances under the QIS sub-section of Appendix G to ensure ongoing monitoring and oversight of unauthorized uses of restrictive interventions. The sub-assurances added were developed to be consistent with global reporting measures that the State developed with the assistance of CMS and Truven through technical assistance to bring quality reporting into the managed care environment in 2014.

The State will be utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

- The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards  
Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
The State has added 2 sub-assurances under the QIS sub-section of Appendix G to ensure ongoing monitoring and oversight of unauthorized uses of restrictive interventions. The sub-assurances added were developed to be consistent with global reporting measures that the State developed with the assistance of CMS and Truven through technical assistance to bring quality reporting into the managed care environment in 2014.

The State will be utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
The State is utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

The Kansas Department for Aging and Disability Services (KDADS-CSP) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue. Information and findings are reported to KDHE waiver managers quarterly/annual reports.

Methods for detecting unauthorized use, overuse or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

MCO as well as CMHC conducts on-going education through the Person Center Planning Process to educate and assess the participant’s knowledge, ability, and freedom from the use of restraints. If it is determined that there is suspected un-authorized use, the KDADS Licensing Staff instructs the CMHC to report to the appropriate hotline and enter an adverse incident report to KDADS PIC team. Immediate remediation would follow the reporting. KDADS staff will be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS PIC Team refers any reports of unauthorized restraints to the MCO for appropriate follow up. MCO outreach to the Person-Centered planning team and providers to investigate the safety of participant and minimize the reoccurrence. MCO manages additional meetings to update Service Plan to ensure safety of the participant on the waiver. KDADS Integrity team reviews the MCO follow up to ensure proper policy and procedures were followed and safety needs of participant are meet.

KDADS Licensing will follow up with the CMHC staff to ensure appropriate supports and services are in place to eliminate the need for restraints.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.

2. Quality Assurance Process including:
   a. Quality Assurance Team including the Program Manager, Quality, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.

3. Quality Assurance Report provided to KDHE via the KDHE Waiver Managers, for review by the State Medicaid Agency (SSMA).
   • The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children through critical incident reviews, regulatory standards, and statute is conducted by KDADS- Licensing through on-going and on-site record review. KDADS Quality Assurance teams interviews of individuals served, guardians if applicable, review of compliance of the Person Center Service Plan. KDADS-Licensing are responsible for addressing all unauthorized restraint with the CMHC to ensure preventative action is taken for the protection of children.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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**Appendix G: Participant Safeguards**

**Appendix G-3: Medication Management and Administration (1 of 2)**

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring:

---

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight:

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**Appendix G: Participant Safeguards**

**Appendix G-3: Medication Management and Administration (2 of 2)**

**c. Medication Administration by Waiver Providers**

*Answers provided in G-3-a indicate you do not need to complete this section*

**i. Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*

- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
ii. **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. **Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).
  
  *Complete the following three items:*
  
  (a) Specify state agency (or agencies) to which errors are reported:

- 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:

  (b) Specify the types of medication errors that providers must report to the state:

  (c) Specify the types of medication errors that providers must report to the state:

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.

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**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.*
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 instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures

N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver
D=Number of unexpected deaths

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State Medicaid Agency
Operating Agency
Sub-State Entity
Other

Specify:

Responsible Party for data collection/generation (check each that applies):
Managed Care Organizations (MCOs)

- ✅ Continuously and Ongoing
- □ Other
  Specify:

- □ Other
  Specify:

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| ✅ 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 resulted in the identification of preventable causes

\[N=\text{Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes}
\]

\[D=\text{Number of unexpected deaths}\]

Data Source (Select one):

- Other
If ‘Other’ is selected, specify:

**Record reviews**

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- Continuously and Ongoing

Performance Measure:
PM 3: Number and percent of unexpected deaths for which the appropriate follow-up measures were taken

Numerator: Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver
Denominator: number of unexpected deaths.

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

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#### b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*
Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures. 

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

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency.

- Annually
- Continuously and Ongoing

### Performance Measure:

Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames

\[
N = \text{Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver}
\]

\[
D = \text{Number of participants' reported critical incidents}
\]

### Data Source (Select one):

- Other

If 'Other' is selected, specify:

Critical incident management system

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Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation

Numerator: Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation

Denominator: Number of waiver participants interviewed by QMS staff or whose records are reviewed

**Data Source** (Select one):
- Record reviews, off-site

If ‘Other’ is selected, specify:

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**Data Aggregation and Analysis:**
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
Denominator: Number of restraint applications, seclusion or other restrictive interventions

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

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<th>Frequency of data collection/generation (check each that applies):</th>
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**Data Aggregation and Analysis:**

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

| ☒ State Medicaid Agency     | ☐ Weekly                                                              |
| ☒ Operating Agency          | ☐ Monthly                                                            |
| ☐ Sub-State Entity          | ✕ Quarterly                                                          |
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|                             | ☐ Continuously and Ongoing                                           |
|                             | ☐ Other                                                              |
### Responsible Party for data aggregation and analysis (check each that applies):

- [ ] State Medicaid Agency
- [ ] Operating Agency
- [ ] Sub-State Entity
- [ ] Other

### Frequency of data aggregation and analysis (check each that applies):

- [ ] Weekly
- [ ] Monthly
- [ ] Quarterly
- [ ] Annually
- [ ] Continuously and Ongoing
- [ ] Other

### Sampling Approach (check each that applies):

- [X] 100% Review
- [ ] Less than 100% Review
- [ ] Representative Sample

#### Describe Group:

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### Performance Measure:

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported

- **Numerator:** Number of unauthorized uses of restrictive interventions that were appropriately reported
- **Denominator:** Number of unauthorized uses of restrictive interventions

### Data Source (Select one):

- Record reviews, off-site

If 'Other' is selected, specify:

- [ ] Other

#### Specify:

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07/05/2023
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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

Numerator: Number of HCBS participants who received physical exams in accordance with State policies
Denominator: Number of HCBS participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:
## Responsible Party for data collection/generation

(choose each that applies):

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### Performance Measure:

**PM 10:** Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan  
Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan  
Denominator: Number of waiver participants with a red flag designation

### Data Source (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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| □ Sub-State Entity | ☒ Quarterly | ☒ Representative Sample  
Confidence Interval = 95/5 |
| ☒ Other  
Specify: MCOs | □ Annually | ☒ Stratified  
Describe Group: proportioned by MCOs  
Continuously and Ongoing |
### Data Aggregation and Analysis:

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  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.

DCF’s Division of Child Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events.

ii. Remediation Data Aggregation

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

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**c. Timelines**

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

☐ No
☐ Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target.
population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the state’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-I: 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.
KDHE operates as the SSMA and KDADS serves as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful participant feedback on the HCBS program. KDADS reviews a statistically significant sample of participants for the Autism (KS.0476) population and the other affected waiver populations under the Quality Improvement Strategy. 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, the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE’s Long-Term Care Committee and the interagency monitoring team and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor’s systems as well as the Managed Care Organizations’ systems. On a routine basis, KDADS’ Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency’s critical incident management system. KDADS worked with CPS, a division within the Kansas DCF and the MCO's and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include, but are not limited to, training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Vineland-3 assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team requires the contracted assessor to provide the following documents for each child assessed:
1. Vineland-3 assessments
2. Referral form from KDADS for the assessment.
3. Approved form from KDADS Program Manager
4. Recommended Service Plan

KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. KDADS Quality Assurance Team requires the Managed Care Organizations to provide the following documents for each child on the Autism Waiver:
1. Person Centered Service Plans (PCSP) (aka: POC/ISP)
2. All PCSP’s for the review period (include documentation of any changes made during the review period)
3. All PCSP’s require individual’s representative/guardian’s, and provider’s signatures; and dates signed.
4. PCSP components include, but not limited to:
   a. Developed according to the process (face to face interview and is signed and dated by the individual and/or their representative/guardian; and
   b. Identified individual’s services in type, scope, amount, duration, frequency as noted in the assessment, to include effective dates; and
   c. Addresses, Needs and Capabilities; Health and Safety Risk Factors; and
   d. Includes individual’s goal(s).
   e. Be understandable to the individual receiving services and persons important to the individual. It must be written in plain language and in a manner that is accessible to the individuals with disabilities and persons with limited English proficient.
   f. Identify the individual and/or entity responsible for monitoring the plan
   g. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation
   h. Be distributed to the individual and others involved in the plan
   i. Include those services the purpose or control of which the individual elects to self-direct
   j. Prevent the provisions of unnecessary or inappropriate services and supports
   k. Identify specific individualized assessed need
   l. Document the positive interventions and supports used prior to any modifications to the PCP
   m. Document less intrusive methods of meeting the need that had been tried but did not work
   n. Include a clear description of the condition that is directly proportionate to the specified assessed need
   o. Include regular collection and review of data to measure the ongoing effectiveness of the modification
   p. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
   q. Include informed consent of the individual
   r. Include an assurance that interventions and supports will cause no harm to the individual
   s. The plan must be reviewed, and revised upon reassessment of functional need at least every 12 months or when the individual’s needs or circumstances change significantly, or at the request of the individual
5. Needs Assessment(s) completed by the MCO within 6 months, which must address:
   a. Physical, and
   b. Behavioral, and
   c. Functional
6. Choice Form/Documentation:
   a. Choice of Waiver services v. Institutional placement
   b. Choice of Self-Direct or Agency-Directed services
   c. Choice of Provider (Provide documentation of individual being shown how to access the list of providers, and noting choice with valid signature and date of individual or their representative/guardian.
   d. Choice of Services (Provide documentation of choice being offered for eligible services, with valid signature and date of individual or their representative/guardian.
7. Case log documentation for the review period, to include contacts with individual such as telephone calls, individual visits, etc….
8. All Notices of Actions to the individual, relevant to the review period. (Inclusive of adverse actions and POC updates.)
9. Documentation of notifications to the individuals made through the 3160 and/or 3161(s) and the 834 report (*Evidence of MCO notification of eligibility by providing copy or screen shot of eligibility) including but not limited to:
   a. Notification of Eligibility
   b. Change of address
   c. Change in POC cost
   d. Change in Client Obligation
   e. Death of Individual
   f. HCBS service termination
g. Individual enters institution, for planned brief stay
10. Evidence of Rights and Responsibilities, discussed with the individual’s representative/guardian. Must be signed and dated by individual’s representative/guardian.
11. Evidence of Appeal and Grievance rights/processes, discussed with the individual’s representative/guardian. Must be signed and dated by individual’s representative/guardian.
12. Back Up Plan for individual and has individual’s representative/guardian’s signature and date
13. Notification of eligibility (documentation of MCOs notice of individual’s eligibility)
14. Evidence of start date of Personal Service Worker
15. Evidence that the individual / family received information on how to report abuse, neglect and exploitation
16. Documentation on “reported use” of restraint application, seclusion or other restrictive interventions
17. Documentation on use of restraint application, seclusion or other restrictive interventions where “appropriate procedures were followed”
18. Documentation on “Critical Incidents” reporting “unauthorized” use of restraint application, seclusion or other restrictive interventions

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

FISC will generate and provide a report regarding findings to the KDADS Program Manager to review and to remediate as necessary. Data analysis is completed and remediated for any assurance or sub-assurance less than 87%. KDADS Program Manager will notify the provider of areas below 87% with details of each finding. The provider will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by the KDADS Program Manager for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, the KDADS Program Manager will continue to monitor through Quality Reviews to ensure compliance. Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.

Findings or concerns on a specific case identified through the review by QMS will be entered in QRT. Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the KDADS Program Manager.

### ii. System Improvement Activities

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b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain participant feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with the state fiscal agent 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 state fiscal agent staff to generate recommended systems changes, which are then monitored and analyzed by the state fiscal agent staff and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the State's Quality Improvement Strategy:

WORK PLAN:
The Operating Agency has convened an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff as of 1/18/2017. The group will meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement. KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures in all 7 1915 c waivers. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (Select one):

- No
- Yes (Complete item H.2b)
b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the State that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

a. Because of other business relationships with the State, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The MCOs make payments 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 1915(b) waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - 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 but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;

- 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 functions under this contract;
  2. Liaison with the State in all matters regarding program integrity;
  3. Development and operations of a fraud control program within the CONTRACTOR claims payment system;
  4. Liaison with Kansas’ MFCU;
  5. Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

The State operating agency Quality Assurance conduct annual MCO reviews and audits which are inclusive of HCBS services.

All providers are subject to 100% review annually by the State operating agency Quality Assurance staff.

100% of Autism waiver providers are audited annually. There is no random sample drawn for this population.

For the Autism waiver, 100% of providers are audited annually by the State operating agency Quality Assurance staff.

Waiver providers are contracted and credentialed by the MCO and bill the MCO directly for services rendered.

### Appendix I: Financial Accountability

#### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability Assurance:**

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

**i. Sub-Assurances:**

- **a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
  
  (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract

\[N=\text{Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract}
\]

\[D=\text{Total number of provider claims}\]
**Data Source** (Select one):
- **Other**
  If 'Other' is selected, specify:
- DSS/DAI encounter data

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<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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✓ Other
Specify:

KanCare Managed Care Organizations (MCOs)

☐ Annually
☐ Stratified
Describe Group:

☐ Continuously and Ongoing
☐ Other
Specify:

Data Aggregation and Analysis:

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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

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

The State work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program. The Quality Improvement Strategy engages program management, contract management and financial management staff of both KDHE and KDADS.

The MCOs are responsible for monitoring for ensuring that service plans are rendered appropriately as well as responsible for the payment to the provider.

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 program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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

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

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

☐ No
☐ Yes
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State is receiving TA assistance to ensure all Waiver quality measures appropriately meet the intent of each assurance. The State is currently targeting 1/1/23 to have new/revised measures implemented.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The capitated rates are developed by a State Contracted Actuary. The resulting rates are certified to and approved by CMS.

Under managed care, HCBS provider rates are determined through contracting with the MCO while the State sets actuarial sound capitation rates that are paid to the MCO for each Waiver beneficiary. The state sets the floor for the minimum rates that are required to be paid by the MCO, however. For the Autism Waiver, the State’s floor rates are based on prior fee for service rates and are available through KMAP. Capitation rates are based on actuarial analysis of historical data for all Autism program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The State’s Contracted Actuary does not set provider floor rates.

All waiver services are included in the capitation rates.

The FMS administrative payments are paid on a monthly basis. While a participant is temporarily hospitalized, the monthly payment would not need to be cancelled or changed as long as the participant is using participant-directed services during the month.

FMS in Kansas works under an employer agent model. Funds received on behalf of the participant, and within the scope of the FMS responsibilities, shall be deposited in accordance with the FMS provider agreement in which such deposits shall be individually accounted by participant. As required by 42 CFR 443.300 et seq, residual funds not dispersed to a participant’s DSW in accordance with federal and state laws, rules and regulations shall be returned in accordance with the FMS provider agreement. Kansas does not require FMS providers to perform the required background checks. This requirement may be taken on by the FMS provider, waiver participant or DSW.

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 delivering Autism waiver services. All claims are either submitted through the MMIS portal, the State’s front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. 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.

Post payment billings are conducted by the MCOs.

The State’s Quality Management Staff (QMS) conducts quarterly and annual reviews, which includes reviewing case file documentation and participant interviews to verify that services on the Service Plan were rendered.

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
Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

☐ The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

☐ The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

☐ The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ Providers are paid by a managed care entity or entities for services that are included in the state’s contract with the entity.
Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The state does not make supplemental or enhanced payments for waiver services.
- Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:
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
Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

- This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- [X] Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.
- [ ] Appropriation of State Tax Revenues to the State 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.
- [X] 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:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

07/05/2023
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):

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal deductible</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Co-Payment</td>
<td></td>
</tr>
<tr>
<td>Other charge</td>
<td></td>
</tr>
</tbody>
</table>

   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.**
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 inCols. 3, 5 and 6 in the following table for each waiver year. The fields inCols. 4, 7 and 8 are auto-calculated based on entries inCols 3, 5, and 6. The fields inCol. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Hospital**

<table>
<thead>
<tr>
<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>548.75</td>
<td>12500.00</td>
<td>13048.75</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
<td>28951.25</td>
</tr>
<tr>
<td>2</td>
<td>699.97</td>
<td>12500.00</td>
<td>13199.97</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
<td>28800.03</td>
</tr>
<tr>
<td>3</td>
<td>861.60</td>
<td>12500.00</td>
<td>13361.60</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
<td>28638.40</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>82</td>
<td>Hospital: 82</td>
</tr>
<tr>
<td>Year 2</td>
<td>82</td>
<td>Hospital: 82</td>
</tr>
<tr>
<td>Year 3</td>
<td>82</td>
<td>Hospital: 82</td>
</tr>
<tr>
<td>Year 4</td>
<td>82</td>
<td>Hospital: 82</td>
</tr>
<tr>
<td>Year 5</td>
<td>82</td>
<td>Hospital: 82</td>
</tr>
</tbody>
</table>

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.

Average Length of Stay is 289 days for each year of the renewal.

The ALOS is calculated based off of the turnover rate, which is the total number of unduplicated persons per year divided by the number of persons served at any point in time: \( \frac{82}{65} = 1.26 \). The average length of stay is 365 days divided by the turnover rate of 1.26, which equals 289 days. Since the point-in-time limit is the same for all 5 years, the ALOS is 289 days for each year of the renewal.

The unduplicated persons served is based upon the approved CMS 372 report for Year 5 (01/01/2015 to 12/31/2015) of the previous waiver. The unduplicated number of participants could not be changed/updated during the current renewal due to Section 9817 ARP MOE requirements.

The point-in-time limit was established during the last waiver renewal to manage waiver expenditures due to legislative appropriation.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1000.48</td>
<td>12500.00</td>
<td>13500.48</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
<td>28499.52</td>
</tr>
<tr>
<td>5</td>
<td>1143.30</td>
<td>12500.00</td>
<td>13643.30</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
<td>28356.70</td>
</tr>
</tbody>
</table>

07/05/2023
Factor D was estimated by utilizing Managed Care encounter data from the Kansas Medicaid Information System and analyzing trends of annual utilization from April 2017 through March 2020. This will only be a projection of MCO encounters and not be reflective of the State’s Capitation payments made to the MCO.

The State assumed increased participation in Family Adjustment Counseling based on a waiver change based on allowing telehealth as an option in the renewal. Additionally, the State adjusted utilization by participants by increasing the unit limit to 60 and estimating that 75% of the limit will be utilized on average.

For Parent Support and Training, the State estimated growth in the first three years of the renewal period based on allowing for telehealth and as place of service. The State also assumed growth in units per participant based on increased availability of services with the telehealth option.

The State has added Self-Directed respite as a new service to this Waiver. The State reviewed Managed Care encounter data from the Kansas Medicaid Information System and evaluated trends of utilization from April 2017 through March 2020 for the existing waiver services. Then, based upon programmatic knowledge and assumptions, the State made its best estimate to project utilization for the new waiver service over the 5 years of the Waiver. The State assumed that approximately 30% of the Waiver participants would utilize this service by Year 5 and assumed growth would occur over that 5-year period in order to reach that target.

For Financial Management Services (FMS), the state is aligning with the utilization of the new self-directed service. FMS will be billed each month for every beneficiary utilizing the self-directed respite service.

**ii. Factor D’ Derivation.** The estimates of Factor D’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D’ was projected by subtracting the Factor D cost estimates from the estimated MCO encounter payments that will be made to the State’s Managed Care Organizations over the period of the Waiver.

**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:

In Kansas, Factor G represents hospitalization costs for KanCare beneficiaries receiving services through an Inpatient Psychiatric facility for individuals aged 21 and younger.

These costs are paid by the state through managed care capitated payments which cover all Medicaid costs. The average all-inclusive capitated costs for these beneficiaries while admitted to the institutional setting averaged approximately $1,700 annually prior to the COVID pandemic which was derived on data from the State’s Medicaid data system based on data from April 2017 through March 2020. Given the length of stay difference between the Waiver and the institutional stay, the State extrapolated the institutional capitated cost based on the Waiver length of stay to determine an historical Factor G cost of approximately $35,000.

Based on the actual state expended capitated rate payment data, the state projects costs of $42,000 annually in the new Waiver period assuming a 20% cost growth along with similar lengths of stay experienced prior to the COVID-19 pandemic. The state assumed cost growth is directly related to the state’s current processes in expansion of the provider network for these inpatient services.

In order to breakout the total capitated cost of $42,000 between Factor G and G’, the state analyzed MCO encounter claims for Waiver Years 1-3 (04/01/2017-03/31/2020) to proportionally split the cost between hospital and other state plan share of cost. This resulted in a Factor G of $33,458 and a Factor G’ of $8,541.

At this point, the state does not currently project substantial increases in utilization or costs during the 5-year Waiver period.

**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:
In Kansas, Factor G’ represents non-hospitalization costs for KanCare beneficiaries receiving services through an Inpatient Psychiatric facility for individuals aged 21 and younger.

These costs are paid by the state through managed care capitated payments which cover all Medicaid costs. The average all-inclusive capitated costs for these beneficiaries while admitted to the institutional setting averaged approximately $1,700 annually prior to the COVID pandemic which was derived on data from the State’s Medicaid data system based on data from April 2017 through March 2020. Given the length of stay difference between the Waiver and the institutional stay, the State extrapolated the institutional capitated cost based on the Waiver length of stay to determine an historical Factor G cost of approximately $35,000.

Based on the actual state expended capitated rate payment data, the state projects costs of $42,000 annually in the new Waiver period assuming a 20% cost growth along with similar lengths of stay experienced prior to the COVID-19 pandemic. The state assumed cost growth is directly related to the state’s current processes in expansion of the provider network for these inpatient services.

In order to breakout the total capitated cost of $42,000 between Factor G and G’, the state analyzed MCO encounter claims for Waiver Years 1-3 (04/01/2017-03/31/2020) to proportionally split the cost between hospital and other state plan share of cost. This resulted in a Factor G of $33,458 and a Factor G’ of $8,541.

At this point, the state does not currently project substantial increases in utilization or costs during the 5-year Waiver period.

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.

<table>
<thead>
<tr>
<th>Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite Care</td>
</tr>
<tr>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Family Adjustment Counseling</td>
</tr>
<tr>
<td>Parent Support and Training (peer to peer) Provider</td>
</tr>
</tbody>
</table>

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
### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (6 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite Care</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>16316.80</td>
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<tr>
<td>Agency Directed:</td>
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<td>15 minutes</td>
<td>5</td>
<td>160.00</td>
<td>3.26</td>
<td>2608.00</td>
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<tr>
<td>Self Directed:</td>
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<td>3.36</td>
<td>13708.80</td>
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<td>Total:</td>
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<tr>
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<td>15 minutes</td>
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<td>5.44</td>
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<tr>
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<td>45.00</td>
<td>10.87</td>
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<tr>
<td>Parent Support and</td>
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<td>5766.36</td>
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<td>Training (peer to peer)</td>
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<tr>
<td>Provider Total:</td>
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<td></td>
</tr>
<tr>
<td>Group</td>
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<td>58.00</td>
<td>6.79</td>
<td>2362.92</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

|                      |            |                |         |                     |                | 04997.63       |
|                      | Total:     | Services       |         |                     |                | 04997.63       |
|                      | Services   | included in    |         |                     |                | capitation:    |
|                      | not included in capitation: | 82          |          |                     |                | Factor D (Divide total by number of participants): | 548.75 |
|                      | Total Estimated Unduplicated Participants: | 82 |          |                     |                | Services included in capitation: | 548.75 |
|                      | Services not included in capitation: | 82 |          |                     |                | Average Length of Stay on the Waiver: | 285 |

07/05/2023
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<tbody>
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<tr>
<td>Agency Directed</td>
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<td>15 minutes</td>
<td>5</td>
<td>160.00</td>
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<td>57397.90</td>
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<td></td>
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<td>82</td>
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<td>99.97</td>
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<td>Factor D (Divide total by number of participants):</td>
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<td></td>
<td></td>
<td></td>
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<td>699.97</td>
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<td></td>
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<tr>
<td>Average Length of Stay on the Waiver:</td>
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<td>289</td>
</tr>
</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3
### Waiver Year: Year 4

#### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (8 of 9)**

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.
### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (9 of 9)**

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**
<table>
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<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
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<td>33089.92</td>
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<td>5</td>
<td>160.00</td>
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<td>2608.00</td>
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<td>Self Directed</td>
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<td>27</td>
<td>336.00</td>
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<td>27</td>
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<td>33760.80</td>
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<td>90.00</td>
<td>3.26</td>
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<td>8802.00</td>
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<td>6.79</td>
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Total: Services included in capitation: 93750.37
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 82
Factor D (Divide total by number of participants):
Services included in capitation: 1143.30
Services not included in capitation:
Average Length of Stay on the Waiver: 285

07/05/2023
Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

   A. The State of Kansas requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
   B. Program Title:
      Home and Community Based Services for the Frail Elderly
   C. Waiver Number: KS.0303
      Original Base Waiver Number: KS.0303.90.R1
   D. Amendment Number:
   E. Proposed Effective Date: (mm/dd/yy)
      01/01/24
      Approved Effective Date of Waiver being Amended: 01/01/20

2. Purpose(s) of Amendment

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

To align this waiver with the submission of the State's 1915(b) application.

3. Nature of the Amendment

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

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Application</td>
<td></td>
</tr>
<tr>
<td>Appendix A</td>
<td></td>
</tr>
<tr>
<td>Waiver Administration</td>
<td></td>
</tr>
<tr>
<td>and Operation</td>
<td></td>
</tr>
<tr>
<td>Appendix B</td>
<td></td>
</tr>
<tr>
<td>Component of the Approved Waiver</td>
<td>Subsection(s)</td>
</tr>
<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td>Participant Access and Eligibility</td>
<td></td>
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<tr>
<td>Appendix C Participant Services</td>
<td></td>
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<tr>
<td>Appendix D Participant Centered Service Planning and Delivery</td>
<td></td>
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<tr>
<td>Appendix E Participant Direction of Services</td>
<td></td>
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<tr>
<td>Appendix F Participant Rights</td>
<td></td>
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<tr>
<td>Appendix G Participant Safeguards</td>
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<tr>
<td>Appendix H</td>
<td></td>
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<tr>
<td>Appendix I Financial Accountability</td>
<td></td>
</tr>
<tr>
<td>Appendix J Cost-Neutrality Demonstration</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Specify:

---

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

1. Request Information (1 of 3)

A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (optional - this title will be used to locate this waiver in the finder):

Home and Community Based Services for the Frail Elderly

C. Type of Request: amendment

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

☐ 3 years  ☐ 5 years

Original Base Waiver Number: KS.0303
Draft ID: KS.006.05.06

D. Type of Waiver (select only one):

Regular Waiver

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

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

× Hospital
  Select applicable level of care
    ☐ Hospital as defined in 42 CFR §440.10
      If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility
  Select applicable level of care
    ☐ Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

07/05/2023
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
- [x] 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
- [x] 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:

  This amendment is being submitted simultaneously with the 1915(b) application.

Specify the §1915(b) authorities under which this program operates (check each that applies):

- [x] §1915(b)(1) (mandated enrollment to managed care)
- [x] §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:
This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

The FE waiver provides community-based services as an alternative to nursing facility care. The waiver promotes independence for the individual in the least restrictive community setting.

KDADS contracts with one provider who is responsible for conducting the State’s functional eligibility assessment for the FE waiver. Waiver participants are assessed every 365 days by the contractor to determine if they meet the level of care required for continued waiver eligibility. The KDADS Quality Management Staff (QMS) perform quarterly reviews of the contracting entity to ensure compliance with the Performance Measures identified in the waiver.

The FE waiver services are a part of a comprehensive package of services provided by the KanCare Managed Care Organizations (MCO). The MCOs, or their designee, conduct a comprehensive needs assessment and develop a Person-Centered Service Plan that includes both state plan services and FE waiver services. There are opportunities for waiver participants to self-direct certain services within the FE waiver. The state also offers agency directed options for all FE waiver services.

The KDADS’ QMS perform quarterly reviews of the MCOs to ensure compliance with their contractual obligations and Performance Measures identified in the waiver.

FE waiver services include: Adult Day Care, Assistive Technology, Comprehensive Support, Enhanced Care Services, Financial Management Services, Home Tele Health, Medication Reminder, Nursing Evaluation Visit, Oral Health Services, Personal Care Services, Personal Emergency Response, and Wellness Monitoring.

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 inpatients of a hospital, nursing facility or ICF/IID.

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

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

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

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

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

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

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

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

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

7. Contact Person(s)

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

Last Name: Graff-Hendrixson  
First Name: Bobbie  
Title: Director of Compliance and Contracting  
Agency: Kansas Department of Health and Environment  
Address: 900 SW Jackson Street  
Address 2: Suite 900N  
City: Topeka  
State: Kansas  
Zip: 66612-1220  
Phone: (785) 296-0149 Ext:  
TTY  
Fax: (785) 296-4813  
E-mail: Bobbie.Graff-Hendrixson@ks.gov

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

Last Name: Segraves  
First Name: Todd  
Title: FE Program Manager  
Agency: Kansas Department for Aging and Disability Services
8. Authorizing Signature

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

Signature: 
State Medicaid Director or Designee

Submission Date: 

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

Last Name: 
First Name: 
Title: 
Agency: 
Address: 
Address 2: 
City: 

07/05/2023
Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

KDADS anticipates no negative impact to waiver participants and the decrease to Factor C is not restricting eligibility, but instead is a technical adjustment to reflect actual utilization patterns.

To clarify, in the original Waiver submission, the projections for the total unduplicated served was not a reduction of slots. The state actually increased the estimates of unduplicated individuals served based on the 2017 numbers as submitted to CMS via the 372 report of 6,109 and for CY 2018 appear to be approximately 5,963. CMS may note that this waiver has seen a trended decrease since 2014 (18: 5,963; 17: 6,109; 16: 6,258; 15: 6,678; 14: 6,857) and that the estimated 6,258 demonstrates and increase from FY17 and FY 18 numbers. The state’s estimates assume that the decrease in caseload will stop and an increase will be seen in the first year of the new Waiver, which would result in an increased caseload, not a decrease in caseload or slots.

It should also be noted that at this time, the State does not limit the number of “slots” on this Waiver as reflected in the point in time in B-3-b, “The state does not limit the number of participants that it serves at any point in time during a waiver year.” The annual unduplicated is an estimate of the number of individuals that will be served throughout the year and is not a number of “slots”, which is a commonly used term used in the State to describe the point in time number.

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.

To clarify, in the original Waiver submission, the projections for the total unduplicated served was not a reduction of slots. The state actually increased the estimates of unduplicated individuals served based on the 2017 numbers as submitted to CMS via the 372 report of 6,109 and for CY 2018 appear to be approximately 5,963. CMS may note that this waiver has seen a trended decrease since 2014 (18: 5,963 17: 6,109; 16: 6,258; 15: 6,678; 14: 6,857) and that the estimated 6,258 demonstrates and increase from FY17 and FY 18 numbers. The state’s estimates assume that the decrease in caseload will stop and an increase will be seen in the first year of the new Waiver, which would result in an increased caseload, not a decrease in caseload or slots.

It should also be noted that at this time, the State does not limit the number of “slots” on this Waiver as reflected in the point in time in B-3-b, “The state does not limit the number of participants that it serves at any point in time during a waiver year”. The annual unduplicated is an estimate of the number of individuals that will be served throughout the year and is not a number of “slots”, which is a commonly used term used in the State to describe the point in time number.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (select one):
   - ○ The waiver is operated by the state Medicaid agency.
     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):
     - ○ The Medical Assistance Unit.
       Specify the unit name:
       
       (Do not complete item A-2)
     - ○ Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.
       Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
       
       (Complete item A-2-a).
     - ○ The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.
       Specify the division/unit name:
       Kansas Department for Aging and Disability Services
In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

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

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

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

b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.

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

d. Correspondence with CMS is copied to KDHE.

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

The services in this waiver are part of the state’s KanCare 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 Strategy. A critical component of that strategy is the engagement of the interagency monitoring, which bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and
services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including interagency monitoring – occur on a quarterly basis.

Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
  Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6:
  KDADS contracts with the Aging and Disability Resource Centers (ADRC) to receive referrals, provide options counseling, complete the standard intake and conduct the functional eligibility assessment for the FE waiver.
  The MCOs, or their designee, conducts a comprehensive needs assessment, develops the Person-Centered Service Plan that includes both state plan services and FE waiver services, offers provider choice, choice between self or agency direction, conducts provider credentialing, provider training, monitoring of service delivery and participates in the comprehensive state quality improvement strategy for the KanCare program.

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

Appendix A: Waiver Administration and Operation

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

- Not applicable
- Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:
  Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.
  Specify the nature of these agencies and complete items A-5 and A-6:
  The Kansas Department for Aging and Disability Services has contracted with the Southwest Kansas Area Agency on Aging, which subcontracts with the state’s 10 other Area Agencies on Aging to function as individual parts of the ADRC. The ADRC’s submit the Functional Assessment tool scores into the state’s KAMIS system. The scores are then calculated by the state to determine LOC eligibility.
  The Aging and Disability Resource Centers (ADRC) are contracted by KDADS to provide Health and Community Based Services (HCBS) assessments to individuals wanting to obtain waiver services through the Frail Elderly Disability (FE) waiver. The ADRC’s submit the Functional Assessment tool scores into the state’s KAMIS system. The scores are then calculated by the state to determine level of care (LOC) eligibility. In addition to assessing individuals for HCBS waivers, the ADRC’s also provide Options Counseling to individuals to educate them on services available within their community. The ADRC’s also operate a call-center that provides information, referrals, and assistance to individuals statewide.

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).
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:

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

Appendix A: Waiver Administration and Operation

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

Contracted entities, including both contracted entities/providers and the state’s contracted MCOs, are monitored through the State’s KanCare Quality Improvement Strategy (QIS), which provides quality review and monitoring of all aspects of the KanCare program

– engaging program management, contract management, and financial management staff from both KDHE and KDADS. All functions delegated to contracted entities are included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process is collaboration between KDHE and KDADS which includes HCBS waiver management staff from KDADS. In addition, the SSMA and the State Operating Agency will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will include oversight and monitoring of all HCBS programs and the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy ensures that the entities contracting with KDADS are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1915(b) waiver, Kansas statutes and regulations, and related policies. Included in the QIS will be ongoing assessment of the results of onsite monitoring and individual reviews with a sample of HCBS waiver participants.

KDHE monitors KDADS’ development of operational processes and collaborates with KDADS to ensure that appropriate administrative oversight components are specified in those processes. Through existing KDHE policy review processes and monthly KDHE Long Term Care (LTC) meeting updates/reports, KDHE ensures implementation of the operational processes to include KDHE monitoring of quality measures via quarterly and ad hoc reporting by KDADS to KDHE, as well as periodic sample review by KDHE.

In addition to the review of contracted entities, the operating agency conducts participant surveys to gather data on access to services and effectiveness of services delivery. Oversight is conducted on a quarterly basis. In instances where the operating agency is primarily responsible for conducting the quality review, the operating agency analyzes and compiles the contracted entities performance results and reports the findings to the Medicaid agency.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than
one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
<th>Local Non-State Entity</th>
</tr>
</thead>
<tbody>
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<td>Participant waiver enrollment</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Waiver enrollment managed against approved limits</td>
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<tr>
<td>Level of care evaluation</td>
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<td>Review of Participant service plans</td>
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<td>Prior authorization of waiver services</td>
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<td>X</td>
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<tr>
<td>Utilization management</td>
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<tr>
<td>Qualified provider enrollment</td>
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<td>X</td>
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<tr>
<td>Execution of Medicaid provider agreements</td>
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<tr>
<td>Establishment of a statewide rate methodology</td>
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<tr>
<td>Rules, policies, procedures and information development governing the waiver program</td>
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<td>X</td>
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<tr>
<td>Quality assurance and quality improvement activities</td>
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<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and Percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports. 

\[ N = \text{Number of Long-Term Care meetings represented by program managers through in-person attendance or written reports} \]
\[ D = \text{Number of Long-Term Care meetings} \]

**Data Source** (Select one):
- Meeting minutes

If 'Other' is selected, specify:

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<tr>
<th>Responsible Party for data collection/generation (check each that applies)</th>
<th>Frequency of data collection/generation (check each that applies)</th>
<th>Sampling Approach (check each that applies)</th>
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<td>State Medicaid Agency</td>
<td>Weekly</td>
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</tr>
<tr>
<td>✗ Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>✗ Quarterly</td>
<td>Representative Sample</td>
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<td>Other Specify:</td>
<td>Annually</td>
<td>Stratified</td>
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<td>Describe Group:</td>
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<td>✗ Continuously and Ongoing</td>
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**Data Aggregation and Analysis:**

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<th>Responsible Party for data aggregation and analysis (check each that applies)</th>
<th>Frequency of data aggregation and analysis (check each that applies)</th>
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</thead>
<tbody>
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<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>✗ Operating Agency</td>
<td>Monthly</td>
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</tbody>
</table>
### Responsible Party for data aggregation and analysis (check each that applies):

<table>
<thead>
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<th>Sub-State Entity</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>× Quarterly</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
</tr>
<tr>
<td>Other</td>
<td>× Continuously and Ongoing</td>
</tr>
<tr>
<td></td>
<td>Other Specify:</td>
</tr>
</tbody>
</table>

### Performance Measure:

Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency  
\[ N = \text{Number of Quality Review reports generated by KDADS, the Operating Agency} \]  
\[ D = \text{Number of Quality Review reports submitted to the State Medicaid Agency} \]

### Data Source (Select one):

- **Other**
  - If 'Other' is selected, specify:
  - Quality review Reports

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

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>× State Medicaid Agency</td>
<td>Weekly</td>
<td>× 100% Review</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td>Other</td>
<td>Anually</td>
<td>Confidence Interval =</td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
<td>Describe Group:</td>
</tr>
</tbody>
</table>

07/05/2023
<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>× State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Annually</td>
</tr>
<tr>
<td>× Continuously and Ongoing</td>
<td></td>
</tr>
</tbody>
</table>

**Data Aggregation and Analysis:**

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

**Data Source (Select one):**

Other
If 'Other' is selected, specify:

**Numbers of Amendment and Renewals**

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
<td>× 100% Review</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence Interval =</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
<td>Stratified</td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
<td>Describe Group:</td>
</tr>
<tr>
<td>Continuously and Ongoing</td>
<td>Other</td>
<td>Specify:</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Specify:</td>
</tr>
</tbody>
</table>

**Data Aggregation and Analysis:**

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>× State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>× Sub-State Entity</td>
<td>× Quarterly</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
<tr>
<td>× Continuously and Ongoing</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Party for data aggregation and analysis (check each that applies):</td>
<td>Frequency of data aggregation and analysis (check each that applies):</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Specify:</td>
</tr>
</tbody>
</table>

**Performance Measure:**
Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency. 

**Data Source (Select one):**
- **Other**
  - If 'Other' is selected, specify:

**Presentation of Waiver's Policy Change**

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>× State Medicaid Agency</td>
<td>Weekly</td>
<td>× 100% Review</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence Interval =</td>
</tr>
</tbody>
</table>

**Other** Specify:

<table>
<thead>
<tr>
<th>Other Specify:</th>
</tr>
</thead>
</table>

**Other Specify:**

<table>
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<table>
<thead>
<tr>
<th>Other Specify:</th>
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</thead>
</table>
Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Weekly</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>× Continuously and Ongoing</td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
</tr>
</tbody>
</table>

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 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 team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

KDHE and KDADS have a process in place to ensure all waiver amendments are reviewed and approved prior to submission to CMS. KDHE has ultimate responsibility for submitting waiver renewals and amendments to CMS.

ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>× State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>× Continuously and Ongoing</td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
</tr>
</tbody>
</table>

iii. Timelines

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

- No
- Yes

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

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

Appendix B: Participant Access and Eligibility

07/05/2023
**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:*

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age Limit</th>
<th>No Maximum Age Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged or Disabled, or Both - General</td>
<td></td>
<td>Aged</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disabled (Physical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disabled (Other)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td>Brain Injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medically Fragile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technology Dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>× Intellectual Disability or Developmental Disability, or Both</td>
<td></td>
<td>Autism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developmental Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intellectual Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Serious Emotional Disturbance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

N/A

**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.

*S 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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>6258</td>
</tr>
<tr>
<td>Year 2</td>
<td>6258</td>
</tr>
<tr>
<td>Year 3</td>
<td>6258</td>
</tr>
<tr>
<td>Year 4</td>
<td>6258</td>
</tr>
<tr>
<td>Year 5</td>
<td>6258</td>
</tr>
</tbody>
</table>

Table: B-3-a

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>

Table: B-3-b

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).

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. Be 65 years of age or older
2. Kansas resident
3. Meet required level of care score on the State’s FE functional assessment instrument
   a. Total Level of Care (TLOC) score of 26 or higher; and
   b. An instrumental activities of daily living (IADL) score of 12 or higher; OR
   c. Two activities of daily living (ADL) impairments and 3 IADL impairments
4. Meet Medicaid Financial eligibility as determined by KDHE

Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. In the event there is a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the waiting list remains with the State (KDHE and KDADS).

Participants would supersede the waiting list process if in effect they fall into one of the following groups:
- Participants transferring directly from another HCBS waiver;
- Participants exiting a Medicaid approved nursing facility through the HCBS Institutional Transition Policy.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)
Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (select one):
   - §1634 State
   - SSI Criteria State
   - 209(b) State

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

- No
- Yes

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

<table>
<thead>
<tr>
<th>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low income families with children as provided in §1931 of the Act</strong></td>
</tr>
<tr>
<td><strong>SSI recipients</strong></td>
</tr>
<tr>
<td>Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121</td>
</tr>
<tr>
<td>Optional state supplement recipients</td>
</tr>
<tr>
<td>Optional categorically needy aged and/or disabled individuals who have income at:</td>
</tr>
<tr>
<td><strong>Select one:</strong></td>
</tr>
<tr>
<td>- 100% of the Federal poverty level (FPL)</td>
</tr>
<tr>
<td>- % of FPL, which is lower than 100% of FPL. Specify percentage:</td>
</tr>
<tr>
<td>Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)</td>
</tr>
<tr>
<td>Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>Medically needy in 209(b) States (42 CFR §435.330)</td>
</tr>
<tr>
<td>Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)</td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>Parents and other caretaker relatives (42 CFR 435.110)</td>
</tr>
</tbody>
</table>

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

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

**Select one and complete Appendix B-5.**

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217
Check each that applies:

× A special income level equal to:

Select one:

○ 300% of the SSI Federal Benefit Rate (FBR)

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

  Specify percentage: __________

○ A dollar amount which is lower than 300%.

  Specify dollar amount: __________

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

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

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

Aged and disabled individuals who have income at:

Select one:

○ 100% of FPL

○ % of FPL, which is lower than 100%.

  Specify percentage amount: __________

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

  × Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

  Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).
Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the state plan

  Select one:

  - SSI standard
  - Optional state supplement standard
  - Medically needy income standard
  - The special income level for institutionalized persons

  (select one):

  - 300% of the SSI Federal Benefit Rate (FBR)
  - A percentage of the FBR, which is less than 300%
    
    Specify the percentage: [ ]
  - A dollar amount which is less than 300%.
    
    Specify dollar amount: [ ]
  - A percentage of the Federal poverty level
    
    Specify percentage: [ ]
  - Other standard included under the state Plan
    
    Specify:
The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

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

Specify:

Specify the amount of the allowance (select one):

- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

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

- The amount is determined using the following formula:

  Specify:

  - Other

    Specify:

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

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

    Select one:

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

    Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):
- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

- Other

Specify:

300% of SSI

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:
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.


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.


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.


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: [ ]
ii. Frequency of services. The state requires (select one):
  - The provision of waiver services at least monthly
  - Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):
  - Directly by the Medicaid agency
  - By the operating agency specified in Appendix A
  - By a government agency under contract with the Medicaid agency.

  Specify the entity:

  - Other
    Specify:

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

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

Qualifications of functional eligibility assessors:

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

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

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

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

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

Frail elderly waiver participants must meet the level of care required for Medicaid Nursing Facility placement. See
Appendix B-1 for the functional and programmatic eligibility criteria for the FE waiver.

The level of care is determined by utilizing the Functional Assessment Instrument (FAI). The FEI is an assessment of an
individual’s capacity to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs),
cognitive limitations and risk factors that are critical to the development of a participant’s Person-Centered Service Plan.

The ADRC shall perform conflict free functional eligibility assessments. The level of care criteria utilized for initial
assessments of FE waiver participants and yearly reassessments of waiver participants is the level of care criteria utilized
by Nursing Facilities. Participants and current participants must meet the Medicaid Long Term Care threshold score
based on an assessment completed with the functional eligibility instrument (FEI). The ADRC assessors will screen for
reasonable indicators of meeting the level of care eligibility prior to administering the functional eligibility instrument.

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

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

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

- Every three months
- Every six months
- Every twelve months
- Other schedule
  Specify the other schedule:
h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

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

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

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

Written and/or electronically retrievable documentation of all evaluations and reevaluations is maintained by the State. The contracting entity uses the state's system of record to house the functional assessments.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services

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

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

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

Data Aggregation and Analysis:
### 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 systems: “Kansas Assessment Management Information (KAMIS) System or its related web applications”

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**Other**

Specify:

- Contracted assessors participate in analysis of this measure’s results as determined by the State operating agency
- Annually
- Continuously and Ongoing

**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

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### Performance Measures

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

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

#### Performance Measure:

Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied  

- N = Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied  
- D = Number of initial Level of Care determinations

### Data Source (Select one):

- Other

If 'Other' is selected, specify:

**Record reviews**

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Confidence Interval = 95% +/- 5%

### Other Specify:

- Contracted assessors

### Annually

**Stratified**

Describe Group:

- Proportionate by MCO

### Continuously and Ongoing

Other Specify:

### Data Aggregation and Analysis:

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

- [x] State Medicaid Agency - Weekly
- [x] Operating Agency - Monthly
- [x] Sub-State Entity - Quarterly

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

- Annual
- Continuously and Ongoing

Other Specify:

- Contracted assessors participate in analysis of this measure's results as determined by the State operating agency
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

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Other
Specify:
Contracted assessors participate in analysis of this measure's results as determined by the State operating agency

Performance Measure:
Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool

\[ N = \text{Number of waiver participants whose Level of Care determinations used the approved screening tool} \]
\[ D = \text{Number of waiver participants who had a Level of Care determination} \]

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

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| Sub-State Entity | Quarterly | Representative Sample
Confidence Interval =
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### Data Aggregation and Analysis:

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</table>

Contracted assessors participate in analysis of this measure's results as determined by the State operating agency. | Annually |

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<tr>
<th>Other Specify:</th>
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</thead>
</table>

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
These performance measures are a part of the HCBS quality strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of the functional eligibility contractors with Kansas will be monitored on an ongoing basis to ensure compliance with the contract requirements.

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

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

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

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<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
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<td>× Operating Agency</td>
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<td>× Quarterly</td>
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<td>Continuously and Ongoing</td>
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<td>KanCare MCOs participate in analysis</td>
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</tr>
</tbody>
</table>

iii. Timelines
   When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.
   ○ No
   ○ Yes
   Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons (LEPP), 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 LEPP. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with LEPP, states are required to capture language preference information. This information is captured in the demographic section of the FEI 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 participant in his/her spoken language. (K.A.R. 30-60-15).

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

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)
a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
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<tbody>
<tr>
<td>Supports for Participant Direction</td>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Adult Day Care</td>
</tr>
<tr>
<td>Other Service</td>
<td>Assistive Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Comprehensive Support</td>
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<td>Other Service</td>
<td>Enhanced Care Service</td>
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<td>Other Service</td>
<td>Home Telehealth</td>
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<td>Oral Health Services</td>
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<td>Personal Care Services</td>
</tr>
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<td>Other Service</td>
<td>Personal Emergency Response System and Install</td>
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<tr>
<td>Other Service</td>
<td>Wellness Monitoring</td>
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</table>

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

- Supports for Participant Direction

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

**Support for Participant Direction:**

- Financial Management Services

Alternate Service Title (if any):

**HCBS Taxonomy:**

**Category 1:**

| 12 Services Supporting Self-Direction |

**Category 2:**

| 12 Services Supporting Self-Direction |

**Category 3:**

Service Definition *(Scope)*:

**Category 4:**

Sub-Category 1:

- 12010 financial management services in support of self-direction

Sub-Category 2:

- 12020 information and assistance in support of self-direction

Sub-Category 3:

Sub-Category 4:
Financial Management Services (FMS) is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model.

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

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

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

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

Payment for FMS

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

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

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

Access to this service is limited to participants who choose to self-direct some or all the service(s) when self-direction is offered.

FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.
Service Delivery Method (check each that applies):

- ✗ Participant-directed as specified in Appendix E
- ✓ Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
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</table>

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Enrolled FMS Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
Enrolled FMS providers will furnish Financial Management Services according to the Kansas model.

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

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

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

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

---

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

---

07/05/2023
Adult Day Care

HCBS Taxonomy:

**Category 1:**

<table>
<thead>
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<tr>
<td>04060 adult day services (social model)</td>
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</table>

**Category 2:**

**Category 3:**

**Category 4:**

**Service Definition (Scope):**

This service is designed to maintain optimal physical and social functioning for HCBS/FE participants. This service provides a balance of activities to meet the interrelated needs and interests (e.g., social, intellectual, cultural, economic, emotional, and physical) of FE participants. This service shall not duplicate waiver services.

This service includes:

- Basic nursing care as delegated or provided by a licensed nurse and as identified in the service plan.
- Daily supervision/physical assistance with activities of daily living (ADLs) to meet the participant's needs, as identified in the Customer Service Worksheet and Person-Centered Service Plan.
- Unit definition is included in the proposed Waiver Application under J-2..d and referenced below.

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

To avoid overlap of services, Adult Day Care 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 may not be provided in the participant’s own residence
- One unit equals 5 hours
- Participants living in an Assisted Living Facility, Residential Health Care Facility, or a Home Plus are not eligible for this service
- Service is limited to a maximum of two units of service per day, one or more days per week
- Registered nurse must be available on-call as needed
- Special dietary needs are not required but may be provided as negotiated on an individual basis between the participant and the provider. No more than two meals per day may be provided
- Transfer, bathing, toileting and dressing are not required but may be provided as negotiated on an individual basis between the participant and the provider as identified in the individual’s Person-Centered Service Plan (service plan) and if the provider is capable of this scope of service
- The following are not covered under this service, but may be covered through the Medicaid State Plan:
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Transportation

Service Delivery Method (check each that applies):

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

07/05/2023
Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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<th>Provider Category</th>
<th>Provider Type Title</th>
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</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Care

Provider Category:
Agency

Provider Type:
KDADS licensed free-standing Adult Day Care Facility, Nursing Facility, Assisted Living Facility, Residential Health Care Facility, and Home Plus

Provider Qualifications

License (specify):

- K.S.A. 39-923 et seq.
- K.A.R. 26-41-203(b)
- K.A.R. 26-42-203(b)
- K.A.R. 28-39-160(b)

Certificate (specify):

Other Standard (specify):

K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge participants for services covered by the program.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.
Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Assistant Services

HCBS Taxonomy:

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<td>14020 home and/or vehicle accessibility adaptations</td>
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</table>
In order to align this waiver service with federal requirements, the state will complete system changes to unbundle Assistive Services and submit a waiver amendment no later than 05/01/2021, in accordance with the timing agreed upon with CMS.

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

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

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

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

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

All participants are held to the same criteria when qualifying for critical situation approval as in accordance with statewide policies and guidelines. Adults who may require Assistive Services whose situation does not meet critical situation criteria may receive services through the Medicaid State Plan if medically necessary.

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 as 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.

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

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

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

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

To avoid overlap of services, Assistive Service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources.

- Purchase or rent of new or used assistive technology is limited to those items not covered under the State Plan.

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

- All Assistive Technology (AT) purchases require prior authorization from Managed Care Organization (MCO’s).
- This service must be cost-effective and appropriate to the participant's needs.
- Payment is for the item or modification and does not include administrative costs.
- Repairs or maintenance are not allowed for home modifications or assistive items.
- Home modification includes only those adaptations that are necessary to accommodate the mobility of the participant.
- Replacements and duplicate items shall not be covered for the first twelve months after the purchase date of the item.
- For home modifications to be authorized in a home not owned by the participant, the owner/landlord must agree, in writing, to maintain the modifications for the time period in which the FE participant resides there.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- External modifications (e.g. porches, decks, and landings) will only be allowed to the extent required to complete an approved request.
- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- If Medicare covers an assistive technology item but denies authorization, FE will cover only the difference between the standardized Medicare portion of the item and the actual purchase price.

The services under the Frail Elderly Waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- ✗ Provider managed
Specify whether the service may be provided by *(check each that applies)*:

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Durable Medical Equipment provider</td>
</tr>
<tr>
<td>Individual</td>
<td>Contractor for Home Modifications or Van Lifts</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

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

Service Type: Other Service  
Service Name: Assistive Services  

**Provider Category:**  
Agency

**Provider Type:**  
Durable Medical Equipment provider

**Provider Qualifications**

**License **(specify):**

- Home Health Agency License, K.S.A. 65-5001 et seq.
- Pharmacy

**Certificate **(specify):**

**Other Standard **(specify):
K.A.R. 129-5-108: The Durable Medical Equipment [DME] shall be available to each beneficiary, with the following limitations: (1) The DME shall be the most economical to meet the beneficiary's need...(6) DME shall be covered for only the following types of beneficiaries: (A) Participants of the Kan Be Healthy program; (B) beneficiaries who require DME for life support; (C) beneficiaries who require DME for employment and; (D) beneficiaries who would require more expensive care if the DME was not provided.

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

DME as a part of Assistive Services may be provided by all of the following:
- Licensed Home Health Agency
- Pharmacy
- Rural Health Clinic (medical supplies only)
- Welding Shop (oxygen only)

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

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:**  
Individual

**Provider Type:**  
Contractor for Home Modifications or Van Lifts

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**
1. Contractors shall affiliate with a local Center for Independent Living.

2. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, then a letter from the county or city must be provided stating licensure or certification is not required.

3. 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:** Comprehensive Support

**HCBS Taxonomy:**

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<thead>
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<th>Category 1:</th>
<th>Sub-Category 1:</th>
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<td>08 Home-Based Services</td>
<td>08030 personal care</td>
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| Service Definition (Scope): | |
|-----------------------------| |

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
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</thead>
</table>
Comprehensive Support offers one-on-one non-medical assistance, observation, and supervision, provided to a cognitively impaired adult to meet their health and welfare needs. The provision of comprehensive support does not entail hands-on nursing care; the primary focus is supportive supervision. Comprehensive Support is to be provided in the individual's choice of housing, including temporary arrangements.

The support worker is present to supervise the participant and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example: read mail, books, and magazines or write letters) may also be provided.

Comprehensive Support is available as an agency or self-directed service.

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

To avoid overlap of services, Comprehensive 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 via the participant's Person-Centered Service Plan.
• Comprehensive Support cannot be provided at the same time as FE Personal Care Services or Enhanced Care Services.
• Comprehensive Support is limited to the participant's assessed level of service need, as specified in the participant's Person-Centered Service Plan, not to exceed twelve (12) hours per 24-hours. Comprehensive Supports is limited to 48 units per day. 1 unit=15 minutes.

• Comprehensive Support is to occur during the participant's normal waking hours. Comprehensive Support in combination with other FE waiver services cannot exceed 24 hours per day.
• Under no circumstances shall a participant's spouse, guardian, conservator, person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a participant be paid to provide Comprehensive Support for the participant.
• Participants residing in an Assisted Living Facility, Residential Health Care Facility or Home Plus must have this service provided by a licensed home health agency.
• An individual providing Comprehensive Support must have a permanent residence separate and apart from the participant.
• This service is limited to those participants who live alone or do not have a regular caretaker for extended periods of time.
• This service shall not be paid while the participant is hospitalized, in a nursing home, or other situation when the participant is not available to receive the service.

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:

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<td>Agency</td>
<td>Home Health Agency, County Health Department</td>
</tr>
<tr>
<td>Individual</td>
<td>Comprehensive Support Worker</td>
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Appendix C: Participant Services
K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge participants for services covered by the program. Entities not licensed by DCF, KDADS, or KDHE must provide the following:

1) A certified copy of its Articles of Incorporation or Articles of Organization. If a corporation or limited liability company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

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

License (specify):

K.S.A. 65-5101 et seq.
K.A.R. 28-51-100 et seq.

Certificate (specify):

Other Standard (specify):

K.A.R. 30-5-59 participant
K.S.A. 65-201 et seq. describes local health departments.
K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge participant for services covered by the program.

- Support worker must be 18 years of age or older.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Comprehensive Support

Provider Category:
Individual

Provider Type:
Comprehensive Support Worker

Provider Qualifications

License (specify):

Certificate (specify):
Other Standard (specify):
- Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider;
- Must be at least eighteen years of age or older;
- Comprehensive Support Worker must have a permanent residence separate and apart from the participant.

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services
C-1/C-3: Service Specification

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

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

Service Title:
Enhanced Care Service

HCBS Taxonomy:

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Service Definition (Scope):

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07/05/2023
Enhanced Care Services provides non-nursing physical assistance and/or supervision during the consumer’s normal sleeping hours in the participant’s place of residence. This assistance includes the following: physical assistance or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and prompting to take medication.

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

Enhanced Care Services can be either an agency directed service or self-directed service.

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

- Only one unit (a minimum of 6 hours and a maximum of 8 hours) is allowed within a 24-hour period.
- ECS in combination with other HCBS services cannot exceed 24 hours within a 24-hour period.
- To avoid overlap of services, ECS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant’s Person-Centered Service Plan.
- The participant’s Service Plan must document an assessed need for this service beyond what can be provided through Personal Emergency Response System (PERS) services.
- ECS must be provided in the participant’s home. Services providers must remain in the Participant’s home for the duration of this service provision in accordance with the Participant’s Service Plan.
- Participants residing in an institution, assisted living facility or residential setting or other type of group home are not eligible for ECS.
- ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest mitigated as ordered by the probate court or a designated representative is appointed to direct the care of the participant. Please see C-2-d, explaining that the guidelines for when legally responsible relatives can provide this service are described there.

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

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

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

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

**Provider Specifications:**

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<th>Provider Type Title</th>
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</tr>
<tr>
<td>Individual</td>
<td>ECS Worker</td>
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</table>

**Appendix C: Participant Services**

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

**Service Type: Other Service**
Service Name: Enhanced Care Service

Provider Category: Agency
Provider Type: ECS Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

1. Provider must be at least eighteen years of age and have a High School diploma or equivalent; and
2. Have the necessary training or skills needed in order to care for the participant, as requested either by the participant or legal representative, qualified medical provider, or KanCare MCO; and
3. Providers must be ready to call a physician, hospital, or any identified contact individuals, or other medical personnel should an emergency arise.
4. The agency must be a Medicaid 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 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: Individual
Provider Type: ECS Worker

Provider Qualifications

License (specify):
Certificate (specify):

Other Standard (specify):

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Telehealth

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11030 medication assessment and/or management

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

11030 medication assessment and/or management
Category 3:  

Sub-Category 3:

Service Definition (Scope):

Category 4:  

Sub-Category 4:
Home telehealth is a remote monitoring system provided to a participant that enables the participant to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the participant's health declines. The provision of home telehealth entails participant education specific to one or more disease (e.g. COPD, CHF, Hypertension, or Diabetes), counseling, and nursing supervision.

Home telehealth automates disease management activities and engages participants with personalized daily interactions and education to build or expand the participant's self-management behaviors. The service will enable telehealth providers, after determining the participant's progress, to motivate behavior changes through user-friendly technology, helping participants meet goals for improved compliance with diet, exercise, medications, medical treatments, and self-monitoring of conditions to lower healthcare costs.

The service benefit and goals are improving the participant's ability to meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.

Remote Monitoring Technology could include, but would not be limited to, cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation and/or touchscreen, vital sign telemonitoring mattress, web applications, or phone apps. The technology would be located in the participant's home, in an area appropriate for the specific technology being used (e.g. a telemonitoring mattress would be in a bedroom, a web application would be located on the participants own computer or device provided specifically for the monitoring).

Telemonitoring services supplement, rather than replace, face-to-face physician visits and would be scheduled with the participant's provider. If the participant requires general supervision and protective oversight, or overnight staff support there would need to be provisions made in the participant's Person-Centered Service Plan (Service Plan) for this supervision.

The provider will access the telehealth system to review each participant's baseline, defined by the participant's physician at enrollment and indicated in the Integrated Service Person-Centered Service Plan, trended survey responses, and vital sign measurements. A licensed nurse will monitor the health status of multiple participants, and is alerted if vital parameters or survey responses indicated a need for follow-up by a health care professional.

Telehealth services would be provided on an individualized basis for participants who have an identified need in the Integrated Person Centered Service Plan. Participant options/information would be provided an discussed during the development of the Service Plan.

Monitoring would be initiated by the participant. Participant's would have full control over the equipment to maintain the right to privacy.

The participant will be trained on how to use designated equipment by the provider and/or equipment supplier. Equipment examples could include items such as a cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation and/or touchscreen, vital sign telemonitoring mattress, web applications, phone apps, etc.

The provider will access the telehealth system to review each participant's baseline, defined by the participant's physician at enrollment, trended survey responses, and vital sign measurements. A licensed nurse will monitor the health status of multiple participants, and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional.

Participants qualify for this service if the participant:

• is in need of disease management consultation and education; and
• has had two or more hospitalizations, including ER visits, within the previous year related to one or more diseases; or
• is using the HCBS Institutional Transition process to move from a nursing facility back into the community.

The provider and/or equipment must train the participant and caregiver on use of the equipment. The provider must also ensure ongoing participant education specific to one or more diseases, counseling, and nursing supervision. Participant education shall include such topics as learning symptoms to report, the disease process, risk factors, and other relevant aspects relating to the disease.

FE home telehealth services is not a duplication of Medicare/Medicaid telehealth services. While the Kansas
legislature calls this service home telehealth, the actual service follows the CMS telemonitoring definition which Medicare does not cover. FE home telehealth is a daily monitoring of the participant's vital sign measurements from the participant's home setting to attempt to divert a crisis episode; whereas Medicare telehealth includes specific planned contacts for professional consultations, office visits, and psychiatry services, usually through video contact.

During the MCO development of the Integrated Service Person-Centered Service Plan approval process, the MCO will confirm there is no prior authorization for Medicaid home telehealth skilled nursing visits. If a prior authorization is identified, FE home telehealth services will be denied.

A back-up plan must be documented in the participant's integrated Service Person-Centered Service Plan in case of equipment malfunction. As part of the back-up plan, a response time must be included in the back-up plan to avert any potential crisis situations.

The services delivered through telemonitoring must comply with applicable State and Federal laws related to the participant's right to privacy.

Home Telehealth is an agency-directed service.

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

To avoid overlap of services, Home Telehealth 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.

Participant must have a land line or wireless connection
• Installation required within 10 working days of approval
• Maximum of two installations per calendar year
• Monthly status reports to the physician and MCO Care Coordinator.
• Minimum monthly participant contact to reinforce positive self-management behaviors
• If participant fails to perform daily monitoring for seven (7) consecutive days, the MCO Care Coordinator must be notified to determine if continuation of the service is appropriate.
• Participants living in an Assisted Living Facility, Residential Health Care Facility, or a Home Plus are not eligible for this service.

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:

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<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Agency</td>
<td>County Health Department; Medicare certified or KDHE licensed Home Health Agency</td>
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</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Telehealth

07/05/2023
Agency

Provider Type:

County Health Department; Medicare certified or KDHE licensed Home Health Agency

Provider Qualifications

License (specify):

K.S.A. 65-5101 et seq.
K.A.R. 28-51-100 et seq.

Certificate (specify):

Other Standard (specify):

K.S.A. 65-201 et seq.
K.A.R. 30-5-59
System equipment capable of monitoring customer vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature, and capable of asking the customer questions that are tailored to the customers diagnosis. The provider and equipment must have needed language options.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3; Service Specification

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

Service Type:

Other Service

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

Service Title:

Medication Reminder Service/Installation

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

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

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

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

Medication Reminder Service is an agency directed service.

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

- To avoid overlap of services, Medication Reminder 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.
  - Routine maintenance of rental equipment is the responsibility of the provider.
  - Repair/replacement of rental equipment is not covered.
  - Rental, but not purchase, of this service is covered
  - This service may be provided in the participants place of residence, excluding Adult Care Homes, Residential Health Care Facilities, Assisted Living Facilities or Home Plus.
  - These systems may be maintained on a monthly rental basis even if the participant is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.
  - Installation of Medication Reminder/Dispenser is limited to one installation per participant per calendar year.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

07/05/2023
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Service/Installation

Provider Category: Agency
Provider Type: Medication Reminder Services Provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):

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

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

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have 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.
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:**
Nursing Evaluation Visit

**HCBS Taxonomy:**

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<th>Sub-Category 4:</th>
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The Nursing Evaluation Visit is a required service provided to participants seeking access to level II Personal Care Services which include: 1) ADL’s that require physical assistance or total support and/or 2) health maintenance activities provided by a personal care attendant through a Home Health Agency, Assisted Living Facility, Residential Health Care Facility, or other licensed provider. The Nursing Evaluation is completed face-to-face with the participant, conducted by an RN employed by the licensed provider prior to the provision of services, and, determines which Level II Personal Care Service Attendant may best meet the needs of the participant and provides any special instructions/requests of the participant regarding the delivery of those services. The RN submits a written report to the participants MCO within 2 weeks of the visit including any observations or recommendations the nurse may have relative to the participant which were identified during the Nursing Evaluation Visit.

**Level II Personal Care Services:**

Service C: ADLs – physical assistance or total support: Bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services

Service D: Health Maintenance Activities-Monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or condition, medication administration and assistance.

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

To avoid overlap of services, Nursing Evaluation 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 face to face evaluation occurs one time, per participant, per provider.
- If a participant chooses a home health agency that has provided nursing services to the participant in the past, and the agency is already familiar with the participant’s health status, a Nursing Evaluation Visit is not required.
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:

<table>
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<th>Provider Category</th>
<th>Provider Type Title</th>
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<tr>
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<tr>
<td>Individual</td>
<td>Registered Nurse licensed in Kansas</td>
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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Evaluation Visit

Provider Category:
Agency

Provider Type:
County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus

Provider Qualifications
License (specify):

K.S.A. 39-923 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 28-51-100 et seq.

Certificate (specify):

Other Standard (specify):

K.S.A. 65-201 et seq. describes local health departments.
K.A.R. 30-5-59, is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; record keeping; accept payment in full, not charge participants for services covered by the program.

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

Verification of Provider Qualifications
Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Nursing Evaluation Visit

**Provider Category:**  
Individual

**Provider Qualifications**

**License (specify):**

- K.S.A. 65-1113 et seq.  
- K.A.R. 60-3-101 et seq.

**Certificate (specify):**

**Other Standard (specify):**

- K.A.R. 30-5-59

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**  
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

**Frequency of Verification:**

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

---

Appendix C: Participant Services

C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Oral Health Services

**HCBS Taxonomy:**

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**Service Definition (Scope):**

Oral Health Services shall mean dental procedures, to include diagnostic, prophylactic, restorative care, and allow for the purchase, adjustment, and repair of dentures. Anesthesia services provided in the dentist’s office and billed by the dentist is included within the scope of this services.

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

- Oral Health Services are limited to the participant’s level of service needed to maintain their health, as assessed by the MCO Care Coordinator and as specified in the participant’s Person-Centered Service Plan. Oral Health services are subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception.

  Exception criteria
  1. Does the participant require emergency treatment to resolve an oral health issue that is life threatening?
  2. How will non-treatment of the oral health issue impact the participants health?

- To avoid overlap of services, Oral Health 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.

- Complete or partial dentures are allowed once every 60 months.
- Orthodontic and implant services are not covered.
- Provision of oral health services for cosmetic purposes is not a covered service.

**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:

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<td>Dentist or Dental Hygienist</td>
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<tr>
<td>Agency</td>
<td>Clinic with a licensed dentist or dental hygienist</td>
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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Oral Health Services

Provider Category:
Individual

Provider Type:
Dentist or Dental Hygienist

Provider Qualifications
License (specify):
K.S.A. 65-1421 et seq.

Certificate (specify):

Other Standard (specify):
K.A.R. 30-5-59, is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; recordkeeping; accept payment in full, not charge customers for services covered by the program.

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.
Provider Category: 
Agency

Provider Type: Clinic with a licensed dentist or dental hygienist

Provider Qualifications
License (specify):
K.S.A. 65-1421 et seq.
Certificate (specify):

Other Standard (specify):
K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; record keeping; accept payment in full, not charge customers for services covered by the program.

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services
C-1/C-3: Service Specification

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

Service Type: Other Service

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

Service Title: Personal Care Services

HCBS Taxonomy:
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<td>08 Home-Based Services</td>
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**Service Definition (Scope):**

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</table>
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
2. Health maintenance activities (HMA)
3. Instrumental Activities of Daily Living (IADLs) in accordance with K.A.R. 30-5-300
4. Assistance and accompaniment for exercise, socialization and recreation activities
5. Assistance accessing medical care

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. Homemaker/chore services provided as part of PCS can only be incidental, and cannot comprise the entirety of the service. PCS performed should be specific to the needs of the waiver recipient as reflected in the personal care service plan.

**Laundry:**
The waiver participant has documented incontinence issues creating excessive laundry. PCS shall only be authorized for the time spent providing assistance with the participant’s excessive laundry.

Individual or legally responsible individual with the authority to direct services who may at some point determine that they no longer want to participant-direct his/her service will have the opportunity to receive the previously approved waiver service, without penalty.

The cost associated with the provider traveling to deliver this service is included in the rate paid to the provider. Non-emergency Medical Transportation (NEMT) service is a state plan service and can be accessed through the participant’s chosen KanCare MCO.

There are three levels of agency-directed PCS, which are referred to as Level I, Level II, and Level III. A combination of Level I (Service A & B) and Level II (Service C & D) can be utilized in the development of the Person-Centered Service Plan (Service Plan) in housing arrangements other than adult care homes. If a combination of Level I and Level II services are included in the Service Plan, the Level II rate shall be paid if both levels of care are provided by the same provider. Level III services will be utilized in the development of the Service Plan for those participants residing in adult care homes. For Boarding Care Homes, the tasks authorized on the Service Plan must fall within the licensing regulations.
Level I
Service A: Home Management of IADLs
Shopping, house cleaning, meal preparation, laundry

Service B: IADLs
Medication set-up, cuing, and reminding (supervision only) ADLs-attendant supervises the participant
Bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services

Level II (An initial RN evaluation visit is necessary) Service C: ADLs – physical assistance or total support:
Bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services

Service D: Health Maintenance Activities
Monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or condition, medication administration and assistance

Level III
IADL services include shopping, house cleaning, meal preparation, laundry, medication setup, cuing or reminding, and treatments. ADL services include bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services. Health Maintenance Activities include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or conditions, and medication administration and assistance.


1. Any resident may self-administer and manage medications independently or by using a medication container or syringe pre-filled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.

2. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.

3. If a facility is responsible for the administration of a resident’s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider’s written order, professional standards of practice, and each manufacturer’s recommendations. Medication Administration/Assistance in a Private Residence (K.A.R. 28-51-108):

A Kansas Department of Health and Environment (KDHE) licensed or Medicare Certified Home Health Agency can provide nursing delegation to aides with sufficient training. The nurse delegation and training shall be specific to the particular participant and their health needs. The qualified nurse retains overall responsibility.
Level I
Service A: Home Management of IADLs
Shopping, house cleaning, meal preparation, laundry

Service B: IADLs
Medication set-up, cuing, and reminding (supervision only) ADLs-attendant supervises the participant
Bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services

Level II (An initial RN evaluation visit is necessary) Service C: ADLs – physical assistance or total support:
Bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services

Service D: Health Maintenance Activities
Monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or condition, medication administration and assistance

Level III
IADL services include shopping, house cleaning, meal preparation, laundry, medication setup, cuing or reminding, and treatments. ADL services include bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompanying to obtain necessary medical services. Health Maintenance Activities include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or conditions, and medication administration and assistance.

1. Any resident may self-administer and manage medications independently or by using a medication container or syringe pre-filled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.
2. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.
3. If a facility is responsible for the administration of a resident’s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider’s written order, professional standards of practice, and each manufacturer’s recommendations. Medication Administration/Assistance in a Private Residence (K.A.R. 28-51-108):
A Kansas Department of Health and Environment (KDHE) licensed or Medicare Certified Home Health Agency can provide nursing delegation to aides with sufficient training. The nurse delegation and training shall be specific to the particular participant and their health needs. The qualified nurse retains overall responsibility.

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

Self-direction is only available for Level I PCS.
Agency-direction is available for Level I, Level II and III PCS.

To avoid any overlap of services, Personal Care Services is limited to those services not covered through the Medicaid State Plan 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.

While Federal rules generally prohibit payments to legally responsible relatives for Personal Care Services, Kansas does allow such payments under the circumstances described in Appendix C-2-d.

• 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. PCS is limited to a maximum of 48 units (12 hours) per day of any combination of Level I and Level II PCS.

This service shall not be paid while the participant is hospitalized, in a nursing home, or other situation when the participant is not available to receive the service.

More than one Personal Care Services attendant will not be paid to provide PCS at the same time. The only exception is when justification is documented on the MCO’s needs assessment and the Care Coordinator log indicating a need for a two person lift or transfer.

Level III PCS may be provided in a Residential Health Care Facility, Assisted Living Facility or Home Plus. Level I and II PCS may not be provided in a Residential Health Care Facility, Assisted Living Facility or Home Plus.

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):

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

Provider Specifications:

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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Care Services

Provider Category:
Agency

Provider Type:
### Home Health Agency

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

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

**Other Standard (specify):**

For agency-directed PCS Level I, Level II and Level III

1. Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment
2. Must be enrolled as a Medicaid provider and contracted with a KanCare MCO
3. Must have a High School Diploma or equivalent or be at least eighteen years of age or older;

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

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

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Personal Care Services

**Provider Category:** Individual  
**Provider Type:** PCS Worker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**
- May only provide Level I PCS.
- Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider;
- Must be at least eighteen years of age or older;

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System and Installation

HCBS Taxonomy:

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Service Definition (Scope):

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Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable participants at high risk of institutionalization to secure help in an emergency. The system is connected to the participant's telephone and programmed to signal a response center once the help button is activated. The participant may wear a portable help button to allow for mobility. PERS is limited to those participants who:
1. who are alone for significant parts of the day, and
2. have no regular attendant (formal or informal) for extended periods of time, and
3. who would otherwise require extensive routine supervision.

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

PERS Installation is the placement of electronic PERS devices in a participant's residence. Participants must have an assessed need for a Personal Emergency Response System.

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

To avoid any overlap of services, Personal Emergency Response System is limited to those services not covered through the Medicaid State Plan 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.

- Routine maintenance of rental equipment is the responsibility of the provider
- Repair/replacement of rental equipment is not covered
- Rental, but not purchase, of this service is covered
- Call lights do not meet this definition
- Once installed, these systems may be maintained on a monthly rental basis even if the participant is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.
- Installation for each participant is limited to twice per calendar year
- This service may be provided in a Residential Health Care Facility, Assisted Living or Home Plus setting.

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:

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Appendix C: Participant Services  
C-1/C-3: Provider Specifications for Service

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

Provider Category: Agency
Provider Type: Personal Emergency Response Provider/Installation Provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):

• Must be contracted with the MCO.
• 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 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 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.
Wellness Monitoring is a process whereby a registered nurse (RN) 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 his/her place of residence without more frequent skilled nursing intervention.

Wellness Monitoring includes checking and/or monitoring the following:

a. Orientation to surroundings
b. Skin Characteristics
c. Edema
d. Personal Hygiene
e. Blood Pressure
f. Respiration
g. Pulse
h. Adjustments to medication

Any changes in the health status of the participant during the visits are then brought to the attention of the MCO Care Coordinator and the physician as needed. Wellness Monitoring requires a written follow-up report within two weeks of the face-to-face visit by the licensed nurse. The report will be sent to the participant’s MCO regarding the findings and recommendation of the licensed nurse.

This service includes nursing diagnosis, nursing treatment, counseling and health teaching, administration/supervision of nursing process, teaching of the nursing process, and execution of the medical regimen.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Wellness monitoring is limited to one face-to-face visit every 55 days, or less frequently, as determined by the MCO Care Coordinator.

To avoid overlap of services, Wellness Monitoring 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 Registered Nurse providing the Wellness Monitoring will not also provide any services performed by a Personal Care Services provider so as to prevent duplicative billing.

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

Wellness Monitoring can be provided in a licensed Assisted Living Facility, Residential Health Care Facility and in a Home Plus facility.

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:

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<td>Wellness Monitoring Agency employing RNs</td>
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<tr>
<td>Individual</td>
<td>Registered Nurse licensed in Kansas</td>
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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:
Wellness Monitoring Agency employing Registered Nurses

Provider Qualifications

License (specify):
State of Kansas RN license: 65-1134. Citation of Kansas nurse practice act. The acts contained in article 11 of chapter 65 of the Kansas Statutes Annotated and amendments thereto or made specifically supplemental thereto shall be construed together and may be cited as the Kansas nurse practice act.

Certificate (specify):

07/05/2023
Other Standard (specify):

- Registered Nurse licensed in Kansas
- KMAP enrolled Medicaid provider

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:
Individual

Provider Qualifications

License (specify):

K.S.A. 65-1113 et seq.
K.A.R. 60-3-101 et seq.

Certificate (specify):

Other Standard (specify):

K.A.R. 30-5-59 is the provider participation requirements for Medicaid which requires but not limited to: application to be submitted; specified credentials be maintained; notification of change of ownership; record keeping; accept payment in full, not charge participants for services covered by the program.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

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

Appendix C: Participant Services

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

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

- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
All HCBS providers shall perform background checks in accordance with the KDADS’ Background Check policy, and shall comply with all regulations related to Abuse, Neglect and Exploitation.

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

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

Background checks are required of employees regardless of whether they are providing a licensed or non-licensed service. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process.

The employer shall submit a request for the following checks:
1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver’s license record check through the Kansas Department of Revenue (KDOR)
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)

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

- No. The state does not conduct abuse registry screening.
- Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

All HCBS providers shall perform background checks in accordance with the KDADS’ Background Check policy.

All HCBS providers are required to pass DCF abuse registry checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

All HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, KDHE and KanCare MCO staff.

KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings.

All HCBS providers are required to pass ANE checks conducted by the following entities.
1. a check for ANE through the Nurse Aid Registry
2. an adult and child ANE check through Department of Children and Families (DCF)

Appendix C: Participant Services
C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.
Appendix C: Participant Services

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

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

- No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of extraordinary care by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.
KDADS recognizes that families as Personal Care Services and Comprehensive Support providers are an important part of our service delivery system. Services that may be furnished by a relative or legal guardian are limited to the scope, duration and amount determined by the MCO needs assessment and authorized in the participant’s person-centered plan.

A guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest is mitigated.

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

Self-directed

Agency-operated

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

- The state does not make payment to relatives/legal guardians for furnishing waiver services.
- The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.
Services that may be furnished by a relative or legal guardian are limited to the scope, duration and amount determined by the MCO needs assessment and authorized in the participant’s person-centered plan.

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. A copy of the special or annual report in which the conflict of interest is disclosed will be provided to the MCO and FMS provider along with the judge’s order approving the annual or special report and determining that there is no conflict of interest for the guardian to be paid to provide supports for the participant under the HCBS program.

2. If the court determines that all potential conflict of interest concerns have not been mitigated, the legal guardian can:
   a. Select someone (family member or friend) to provide the HCBS services to the participant. If a family member or friend is not available, the participant’s selected MCO or FMS provider can assist the legal guardian in finding a direct support worker or seeking alternative HCBS service providers in the community. OR
   b. Select someone (family member, friend, non-paid guardian) to appoint as a Designated Representative to develop the integrated service plan and direct the participant’s services under HCBS.

3. An activated durable power of attorney (A DPOA who is currently authorized to make financial, medical or other decisions on behalf of the participant) is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual’s care (hire, fire, manage, training, and monitor direct support workers).

4. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available to the participant if the exception was not granted.

Legal guardians may be paid for providing PCS and Comprehensive Support Service whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

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

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

Other policy.

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

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

Appendix C: Participant Services  
**Quality Improvement: Qualified Providers**

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

a. **Methods for Discovery: Qualified Providers**

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

i. **Sub-Assurances:**

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

   **Performance Measures**

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

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

   **Performance Measure:**
   
   Number/percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services

   \[ \text{N} = \text{Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc. prior to furnishing waiver services} \]

   \[ \text{D} = \text{Number of all new licensed/certified providers} \]

   **Data Source** (Select one):

   Other

   If ‘Other’ is selected, specify:

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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
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KanCare Managed Care Organization (MCO) Reports and and record reviews

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Describe Group: Proportionate by MCO |
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#### Other

Specify:

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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 = \text{Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements} \\
D = \text{Number of enrolled non-licensed/non-certified providers}
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KanCare Managed Care Organizations (MCOs)

x Annually
x Stratified Describe Group:
Proportionate by MCO

x Continuously and Ongoing

Other Specify:

Data Aggregation and Analysis:
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

\[ N = \text{Number of new non-licensed/non-certified providers} \]
\[ D = \text{Number of all new non-licensed/non-certified providers} \]

Data Source (Select one):
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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,
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

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| × Other  
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  Describe Group: Proportionate by MCO |
| × Continuously and Ongoing | Other  
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× 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.
Kansas uses an ongoing survey and evaluation process to verify that providers continue to meet licensing and/or certification standards and adhere to other state standards. Adult care homes are licensed by the Kansas Department for Aging and Disability (KDADS) or the Kansas Department of Health and Environment (KDHE), depending on the type of facility. In-home care providers are licensed by KDHE. Both agencies utilize a similar process to evaluate providers. By statute, the average time between surveys statewide must not exceed 12 months. The surveying agency maintains a database of licensed providers and the month in which their annual surveys are due. The agencies use this database to assign surveyors each month to evaluate the providers identified.

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

State staff request, approve, and assure implementation of 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 QIS and the operating protocols of the interagency monitoring team.

### ii. Remediation Data Aggregation

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

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### c. Timelines

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

- No
- Yes

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

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

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**Appendix C: Participant Services**

07/05/2023
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.*

  ![Limit(s) on Set(s) of Services](image)

  **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.*

  ![Prospective Individual Budget Amount](image)

  **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.*

  ![Budget Limits by Level of Support](image)

  **Other Type of Limit.** The state employs another type of limit.

  *Describe the limit and furnish the information specified above.*

  ![Other Type of Limit](image)

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 07/05/2023
441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Service Plan

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

   - Registered nurse, licensed to practice in the state
   - Licensed practical or vocational nurse, acting within the scope of practice under state law
   - Licensed physician (M.D. or D.O)

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

   Specify qualifications:

   Social Worker

   Specify qualifications:

   Other

   Specify the individuals and their qualifications:
Kansas has contracted with three 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 Person-Centered Service Plan (Service Plan) development using their internal staff to provide that service. In addition, conflict has been mitigated by Kansas separating the level of care (LOC) determination from any HCBS delivery or Service Plan development. Additional safeguards have been put in place to ensure that there is no conflict of interest in this function, including the operational strategies for each MCO that are described in detail at Section D1(d) of this appendix.

Regarding Aetna: (Clinical) Service Coordinator positions require a registered nurse (RN) or a licensed, master’s level behavioral health professional (e.g. LMSW, 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 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Select one:

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.
MCOs and providers follow the processes outlined in the KDADS’ Person-Centered Service Plan policy to provide the individual with the maximum amount of opportunity to direct and be actively engaged in the person-centered planning process.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

State Response: Needs Assessment(s) completed by the MCO within 6 months, which must address:

a. Physical, and
b. Behavioral, and
c. Functional

Each of these areas must be addressed in the Person-Centered Service Plan.

b) All applicants for program services must undergo a functional eligibility assessment to determine functional eligibility for the FE waiver. The FEI is utilized to determine the level of care (LOC) eligibility for the FE waiver. The state’s functional eligibility contractor conducts an assessment of the individual within the time frame specified in the contract, unless a different time frame is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant within six months and must address physical, behavioral and functional needs in the Person-Centered Service Plan that identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant will complete a Participant Interest Inventory (PII). The PII is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Service Plan meeting and will use the PII to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

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

d) Through the various assessments and Service Plan related documents described in b) above, the participant’s goals, needs and preferences are at the forefront of developing their Service Plan. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.
e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS’ Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, upon MCO notification or awareness of necessitating circumstances. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant’s disability. Additional meetings may be necessary due to changes in condition or circumstances.

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

g) The requirements for how and when the Service Plan are updated are specified in the KDADS’ Person-Centered Service Plan policy. The MCOs conduct periodic reviews, as specified by the KanCare MCO contracts, to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant’s disability. Additional meetings may be necessary due to changes in condition or circumstances. Additional Person-Centered Service Plan meetings may be necessary due to changes in condition or circumstance that require updates to the participant’s plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant’s wishes and needs:

a) Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability;

b) Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan;

c) Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater;

d) Upon the request of any waiver participant, guardian or legal representative;

e) Any health and/or safety concern;

f) Any change in needs for an HCBS recipient not listed above.

Appendix D: Participant-Centered Planning and Service Delivery

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

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.
The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument, which identifies potential risk factors. The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers. The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (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:

- 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, and will be retained at least as long as this requirement specifies.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.
The MCOs are responsible for monitoring the implementation of the Person-Centered Service Plan and for ensuring the health and welfare of the participant with input from the FE Program Manager and KDADS Regional Field Staff. Service Plan implementation is assessed through the KanCare Quality Strategy (which includes all of the HCBS waiver performance measures). Kansas also monitors the Adverse Incident Reporting system and implements corrective action plans for remediation with the MCOs.

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether or not to self-direct their services;
- Services meet participant’s needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant’s health and safety are assured, to the extent possible; and
- Participants have access to Medicaid State Plan services when the participant's need for services has been assessed and determined medically necessary.

Individual monitoring by the MCOs is defined as:
- Face-to-face meetings will occur in accordance with the Person-Centered Service Plan policy.
- Face-to-face meetings between MCO and participant are required every six months to evaluate the participant’s ongoing needs.
- Face-to-face meetings are expected if the participant has a significant change in needs, eligibility, or preferences that will modify the participant’s current Person-Centered Service Plan.
- Contact with the participant on a monthly basis is required if the participant’s health and welfare needs are at risk of significant decline or the participant is in imminent risk of death or institutionalization.

In addition, the Person-Centered Service Plan and choice are monitored by state quality review staff as a component of waiver assurance and minimum standards. Any issues in need of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation and reported to the FE 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, and are included in the HCBS quality improvement strategy which is regularly reviewed and adjusted. The HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency are part of this strategy.

State staff request, approve, and ensure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:
Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

   a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose service plans address participants’ goals

\[
N = \text{Number of waiver participants whose service plans address participants' goals}
\]
\[
D = \text{Number of waiver participants whose service plans were reviewed}
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Data Source (Select one):

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If ’Other’ is selected, specify:

Record reviews

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07/05/2023
### Specify:
KanCare Managed Care Organizations (MCOs)

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- **Annually**

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- **Continuously and Ongoing**

### 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

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95% +/- 5% |
| × Other  
Specify:  
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Describe Group:  
Proportionate by MCO |
| × Continuously and Ongoing | Other  
Specify: | |

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- **Other**: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency.

### Frequency of data aggregation and analysis (check each that applies):

- **Annually**

### 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

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency.

### 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

\[ N = \text{Number of waiver participants (or their representatives) who were present and involved in the development of their service plan} \]

\[ D = \text{Number of waiver participants whose service plans were reviewed} \]

**Data Source** (Select one):
- **Other**
  If ‘Other’ is selected, specify:

**Record reviews**

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Specify:

KanCare MCOs participate in the analysis of this measure’s results as determined by the State Operating Agency

Performance Measure:
Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver

N = Number of waiver participants whose service plans were developed according to the processes in the approved waiver

D = Number of waiver participants whose service plans were reviewed

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

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KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency.

Data Aggregation and Analysis:

- 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

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Confidence Interval =  
95% +/- 5% |
| ✗ Other Specify: | Annually | ✗ Stratified  
Describe Group:  
Proportionate by MCO |
| KanCare Managed Care Organizations (MCOs) | ✗ Continuously and Ongoing | Other  
Specify: |
| Other Specify: | | |
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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency.

### Performance Measure:

Number and percent of service plans reviewed before the waiver participant's annual redetermination date

\[N=\text{Number of service plans reviewed before the waiver participant's annual redetermination date}\]

\[D=\text{Number of waiver participants whose service plans were reviewed}\]

**Data Source (Select one):**

Other

If 'Other' is selected, specify:

Record reviews

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<td>× Less than 100% Review</td>
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### Sub-State Entity
- **Quarterly**

### Representative Sample
- **Confidence Interval =**
  - 95% +/- 5%

### Other Specify:
- KanCare Managed Care Organizations (MCOs)

### Annually
- **Stratified**
- **Describe Group:**
  - Proportionate by MCO

### Continuously and Ongoing
- **Other Specify:**

### Data Aggregation and Analysis:

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| × Other
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| | × 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

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

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

**Data Source** (Select one):
Other

If ‘Other’ is selected, specify:

Electronic Visit Verification (EVV) reports and record reviews

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### Performance Measures

**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 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**

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Confidence Interval = 95% +/- 5%
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

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

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Confidence Interval = 95% +/- 5%

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

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**Data Aggregation and Analysis:**

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**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**

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<td>☑ Operating Agency</td>
<td>☐ Monthly</td>
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### Responsible Party for data aggregation and analysis (check each that applies):

- [x] Sub-State Entity
- [ ] Other
  - Specify:

### Frequency of data aggregation and analysis (check each that applies):

- [x] Quarterly
- [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 the ADRCs, MCOs, DCF and other stakeholders to monitor the HCBS quality strategy and performance standards and discuss priorities for remediation and improvement. The HCBS quality strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Quality Management Specialists during the Quality Survey Process, 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 engage with KDADS staff to ensure strong understanding of Kansas’ waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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**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 the HCBS Quality Review process. The process is 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 HCBS quality strategy and the operating protocols of the interagency monitoring team. 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)**

<table>
<thead>
<tr>
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### c. Timelines

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

- No
- Yes

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

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

### Appendix E: Participant Direction of Services

**Applicability (from Application Section 3, Components of the Waiver Request):**

- Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.
CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The state requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.
a) All participants of FE waiver services have the opportunity to choose the KanCare Managed Care Organization (MCO) that will support them in overall service access and care management. The opportunity for participant direction (self-direction) of Service Provider is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100).

This opportunity includes specific responsibilities required of the participant, including:

• Recruitment and selection of Service Provider, back-up SERVICE PROVIDERS with Service Providers;
• Assignment of service provider hours within the limits of the authorized services;
• Complete an agreement with an enrolled Financial Management Services (FMS) provider;
• Referral of providers to the participant's chosen FMS provider;
• Provider orientation and training;
• Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan (Service Plan), including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
• Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
• Other monitoring of services; and
• Dismissal of attendants, if necessary.

b) Participants are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant’s Service Plan. The MCO assists the participant with identifying an FMS provider and related information is included in the participant’s Service Plan. The MCO supports the participant who selects self-direction of services by monitoring services to ensure that they are provided by Personal Care attendants and Enhanced Care Services attendants in accordance with the SERVICE PLAN and the needs assessment, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) The Financial Management Services provider offers supports to the participant as described in Appendix C. The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider.

FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for Information and Assistance functions including but not limited to:

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

d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. Select one:

- **Participant: Employer Authority.** As specified in Appendix E-2, Item a, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

- **Participant: Budget Authority.** As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

- **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

- **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

- **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

- Waiver is designed to support only individuals who want to direct their services.

- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria
Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction option is available for the following services:

- Comprehensive Support
- Enhanced Care Services
- Financial Management Services
- Personal Care Services

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 Direct Support Worker(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.

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

| a) Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self-direct services:
| • the limitation to Service Providers services;
| • the need to select and enter into an agreement with an enrolled FMS(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 MCO they have selected;
| • the requirements of SERVICE PROVIDERS;
| • 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 Program Manager, KDADS Regional Field Staff, and is also available through the online version of the FE Waiver Policies and Procedures Manual.

| c) "Information regarding self-directed services is initially provided by the MCO during the Service Plan process, at which time the participant choice form and Service Plan 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.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

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.

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Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one:

- Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

  Specify whether governmental and/or private entities furnish these services. Check each that applies:

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

  The waiver service entitled:
Financial Management Services

- FMS are provided as an administrative activity.

Provide the following information

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

Enrolled FMS providers will furnish FMS using the Employer Authority model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.

Organizations interested in providing FMS are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

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

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are reimbursed a monthly fee per participant through MMIS. The per member per month payment is based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. FMS providers contract with the MCOs for final payment rates, which cannot be less than the current FFS rate.

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

<table>
<thead>
<tr>
<th>Supports furnished when the participant is the employer of direct support workers:</th>
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<tbody>
<tr>
<td>✗ Assist participant in verifying support worker citizenship status</td>
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<tr>
<td>✗ Collect and process timesheets of support workers</td>
</tr>
<tr>
<td>✗ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</td>
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<tr>
<td>Other</td>
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</table>

Specify:

Supports furnished when the participant exercises budget authority:
Maintain a separate account for each participant’s participant-directed budget
Track and report participant funds, disbursements and the balance of participant funds
Process and pay invoices for goods and services approved in the service plan
Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

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

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
(a) The State assess the performance of the FMS providers through the annual GAAP audit reports, performed by an independent CPA, submitted to KDADS. In addition, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit KDHE or KDADS, their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59). KDADS monitors and verifies accurate tracking of service provided by self-directed providers and paid out through the FMS providers via the Electronic Visit Verification system and accompanying suite of reports. State and MCO staff work together to address/remediate any issue identified in accordance with the KDADS Financial Management Service policy. FMS providers contract with the MCOs to support KanCare members and are included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

(b) KDADS is responsible for the monitoring that occurs through the EVV system. The MCOs are accountable to ensure the FMS providers comply with their contract and State policy which outlines the requirements for annual GAAP audits. KDADS accepts the remittance for unused funds from the FMS providers and remits the federal portion to KDHE for disbursement back to Medicaid.

(c) The MCOs verify that FMS providers meet provider qualification requirements in the HCBS waivers in accordance with the KDADS Provider Qualifications policy. The FMS providers are responsible for obtaining a GAAP audit each year. The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ state wide single audit each year.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

× Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Emergency Response System and Installation</td>
<td>×</td>
</tr>
<tr>
<td>Participant-Directed Waiver Service</td>
<td>Information and Assistance Provided through this Waiver Service</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td>X</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>X</td>
</tr>
<tr>
<td>Home Telehealth</td>
<td></td>
</tr>
<tr>
<td>Medication Reminder Service/Installation</td>
<td></td>
</tr>
<tr>
<td>Adult Day Care</td>
<td></td>
</tr>
<tr>
<td>Assistive Services</td>
<td></td>
</tr>
<tr>
<td>Nursing Evaluation Visit</td>
<td></td>
</tr>
<tr>
<td>Wellness Monitoring</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Support</td>
<td></td>
</tr>
<tr>
<td>Oral Health Services</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td></td>
</tr>
</tbody>
</table>

**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:

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**Appendix E: Participant Direction of Services**

**E-1: Overview (10 of 13)**

**k. Independent Advocacy (select one).**

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent advocacy is available to participants who direct their services through the Disability Rights Center of Kansas (DRC), the state's Protection and Advocacy organization. DRC is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC operates eight federally authorized and funded protection and advocacy programs in Kansas. Participants are referred directly to DRC from various sources, including KDADS. These organizations do not provide direct services either through the waiver or through the Medicaid State Plan.

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**Appendix E: Participant Direction of Services**
I. 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. At any time, if the participant chooses to discontinue the self-direct option, he/she is to:

• Notify all providers as well as the FMS (FMS) provider.
• Maintain continuous attendant coverage for authorized Attendant Care Services and/or Enhanced Care Services.
• Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the participant, to allow for the coordination of service provision.

The duties of the participant's KanCare MCO are to:

• Explore other service options and complete a new Participant Choice form with the participant; and
• Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources
• Work with the participant to maintain continuous coverage as outlined and authorized in the participant's Service Plan.
• The MCO, though their care management and monitoring activities, works with the participant's self-directed provider to assure participant health and welfare during the transition period.
• Ensure open communication with both the participant and the self-directed provider, monitor the services provided, and gather continual input from the participant as to satisfaction with their services.

Appendix E: Participant Direction of Services

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.
The MCO may, if appropriate, discontinue the participants' choice to direct their services when, in the 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 to KDADS and there must be concurrence on the reason to remove participant-direction and the following conditions will be compromised if the participant-direction continues:

- The health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS.
- The MCO and FMS Provider have documentation showing that the participant has participated in the training as outlined in E1b&c: Description of Participant Direction, and further training will not result in the needed outcome to ensure the health and welfare needs of the participant will be met.
- The PCS is not providing the services as outlined on the PCS Skilled worksheet, and the situation cannot be remedied;
- The participant is at risk for fraud, abuse, neglect and exploitation
- The participant is falsifying records resulting in claims for services not rendered.
- 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-directed services as an alternative. If the participant chooses the alternative provider-directed services, the MCO will assess the participant's needs and coordinate services according to the individual's health and safety needs.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Number of Participants</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>3547</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>3646</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>3744</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>3843</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>3942</td>
<td></td>
</tr>
</tbody>
</table>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. Select one or both:

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ✕ Recruit staff
- ✕ Refer staff to agency for hiring (co-employer)
- ✕ Select staff from worker registry
- ✕ Hire staff common law employer
- ✕ Verify staff qualifications
- ✕ Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

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

- ✕ Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

> It does not vary from Appendix C-2-a.

- ✕ Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- ✕ Determine staff wages and benefits subject to state limits
- ✕ Schedule staff
- ✕ Orient and instruct staff in duties
- ✕ Supervise staff
- ✕ Evaluate staff performance
- ✕ Verify time worked by staff and approve time sheets
- ✕ Discharge staff (common law employer)
- ✕ Discharge staff from providing services (co-employer)

**Other**

Specify:
Appendix E: Participant Direction of Services

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

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

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

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

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the state's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.
iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Kansas has contracted with independent assessors to conduct level of care determinations (functional eligibility). Decisions made by the independent assessors are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors with their decision on the LOC determination/redetermination.

Grievance, Appeal, and Fair Hearing Rules and Procedures.

Applicants/beneficiaries may file only a fair hearing for an adverse decision by MCO:

KanCare Managed Care Organizations (MCOs) are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member.

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

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

Notices of Fair Hearing are housed with KDADS Legal Department who store and track all Fair Hearing Notices.

An appeal can only occur under the following circumstances:

- If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
- Members will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: Members or (a friend, an attorney, or anyone else on the member's behalf can file an appeal).
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 60 days calendar days plus 3 calendar days after the participant has received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant’s appeal will be resolve in 45 calendar days.

Fair Hearings

A member may request a Fair Hearing upon receiving a Notice of Action.

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

If the participant is not satisfied with the decision made on the appeal, the participant or their representative may ask for a fair hearing. The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision.

The request be submitted in writing and mailed or faxed to:
Office of Administrative Hearings 1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

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

For all KanCare MCOs:
In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs’ member web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

The State requires that all MCOs define an “action” pursuant to the KanCare contract and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event their Medicaid application is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one:

- No. This Appendix does not apply
- Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. Select one:

- No. This Appendix does not apply
- Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:
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).

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:

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 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:

KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate
law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days,
of receiving the information. Outside of working house, the reports shall be submitted to DCF on the first working day
that the Kansas Department for Children and Families is in operation after the receipt of such information.

All other adverse incidents as defined by KDADS in this section must be reported directly into the AIRS no later than 24
hours of becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and

- 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 AIRS.

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 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 situation. Anyone who suspects an adult is experiencing any of the
above types of DCF reportable events or KDADS adverse incidents may also report it through the DCF hotline.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or
families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including
how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities
when the participant may have experienced abuse, neglect or exploitation.
The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these topics are provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development. Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant’s Person-Centered Service Plan. The information provided by the MCOs is consistent with the state’s Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.
• The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of Adults, the State of Kansas per K.S.A. 39-1431 requires when persons mandated to report suspicion that an Adult 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. 39-1431 for Adults, 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 and requires protective services. DCF will determine if the reportable event will be handled by Adult Protective Services (APS). 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 time frames 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 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.

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 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 and requires protective services.
2. DCF will determine if the reportable event will be handled by Adult Protective Services (APS). 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 Adult Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.

All case decisions/findings shall be staffed with the APS 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 Adult abuse/neglect on the same day, or the next business day, of the case finding decision.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.
The state entity or entities responsible for overseeing the operation of the incident management system:

Kansas Department for Children and Families (DCF) is responsible for overseeing the reporting of and response to all reportable events related to Abuse, Neglect, Exploitation and Fiduciary Abuse. DCF maintains a database of all reportable events and transfers pertinent information from the database to AIRS.

KDADS is the entity responsible for overseeing the operation of the web-based adverse incident management system called AIRS, and responding to incidents reported in AIRS.

• The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

The KDADS Program Integrity Manager will, on a monthly basis, provide an AIR System Reconciliation Report to DCF-APS and CPS, which includes the number of all incidents KDADS received from each entity in the reported month. The purpose of this report is to verify all incidents reported to DCF-APS and CPS that require KDADS review were subsequently provided to KDADS. KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

The KDADS Program Quality Management Specialists 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
a. **Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- The state does not permit or prohibits the use of restraints

  Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraints. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

• Methods for detecting use of restraint and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out and will not be investigated, or investigated and found 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.

A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation, while screened out does not meet the statutory requirements for a DCF investigation. The significance of the DCF determination of screened in or out status is that, DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

• How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:
1) AIR performance data on each health and welfare performance measure as identified in each HCBS waiver
2) Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.)
3) Trend analysis on each adverse incident
4) Remediation efforts by health and welfare performance measure as identified in each HCBS waiver
5) Remediation efforts by each adverse incident

• The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

• The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:
• Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents
• Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident
• Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

○ The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restrictive interventions. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of restrictive intervention and ensuring that all applicable state requirements are followed:

All adverse incidents (including all unauthorized use of restrictive interventions) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on 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. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation, while screened out does not meet the statutory requirements for a DCF investigation. The significance of the DCF determination of screened in or out status is that, DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

- 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.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
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 restrictive interventions 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 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. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation, while screened out does not meet the statutory requirements for a DCF investigation. The significance of the DCF determination of screened in or out status is that, DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

- 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.

☐ The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

☐ No. This Appendix is not applicable (do not complete the remaining items)
☐ Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.
Assisted Living Facilities, Residential Health Care Facilities, and Homes Plus operating in the state of Kansas are required to be licensed by the Kansas Department for Aging and Disability (KDADS). Regulations for these types of facilities require that a licensed nurse perform an assessment on each resident before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This assessment is used to determine whether or not the resident can manage medications safely and accurately without staff assistance or if the facility will be responsible for administration of the resident’s medications. Only licensed nurses and medication aides are authorized to administer and manage medications for which the facility has responsibility.

Regulations require that administration of each resident's medication be documented in the resident's record immediately before or following completion of the task. Licensed nurses and medication aides maintain record of the receipt and disposition of all medications managed by the facility for an accurate reconciliation. A licensed pharmacist must conduct a medication regimen review at least quarterly for each resident in an assisted living facility or residential health care facility whose medication is managed by the facility and each time the resident experiences any significant change in condition. A licensed pharmacist or licensed nurse must conduct a medication regimen review at least quarterly for each resident in a home plus whose medication is managed by the facility and each time the resident experiences any significant change in condition. The medication regimen review is kept in each resident's clinical record. Each resident who self-administers medication is offered a medication regimen review to be conducted by a licensed pharmacist, or a licensed nurse if the resident lives in a home plus, at least quarterly and each time the resident experiences a significant change in condition. Evidence of the resident's decision and, if applicable, the medication regimen review, are to be maintained in the resident's clinical record.

Kansas Statute (K.S.A.) 39-935 requires the Kansas Department for Aging and Disability (KDADS), the state's adult care home licensing and survey agency, conduct at least one unannounced inspection of each adult care home within 15 months of any previous inspection to determine whether the adult care home is complying with applicable statutes, rules, and regulations relating to the health and safety of the residents, and that the statewide average interval between inspections not exceed 12 months. Review of each adult care home's medication management system, including review of the sample residents' clinical records, is included in these inspections. When problems or harmful practices are identified, the State's adult care home licensing and survey agency follows up to address such identified practices.

- 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 Field Staff.

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.
First-line responsibility for monitoring participant medication regimens resides with the medical professionals who prescribe medications. Second-line responsibility for monitoring participant medication lies with the licensed pharmacist or licensed nurse responsible for completing a quarterly medication regimen review for each participant whose medication is managed by licensed facility staff.

The licensed pharmacist or licensed nurse is responsible for notifying the resident's medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist must notify a licensed nurse within 48 hours of any variance identified in the resident’s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident’s medical care provider.

KDADS adult care home survey staff review each adult care home's medication management system to ensure it meets regulatory requirements through observation of facility staff and review of resident clinical records. Medication administration policies and procedures are reviewed for each adult care home by verifying adequacy of the following:

- Assessment of medication management provided in the facility, including medication pass observation if a problem is identified;
- Facility procedures and processes in place regarding the acquiring, receiving, dispensing and administering of medications, including use of controlled medications; and
- Medication access and storage.

Selected resident's clinical records are reviewed to determine if a pharmacist or licensed nurse has completed the required medication regimen reviews to identify any potential or current medication-related problems, including the following:

- Lack of clinical indication for use of medication;
- Use of a subtherapeutic dose of any medication;
- Failure of the resident to receive an ordered medication;
- Medications administered in excessive dosage, including duplicate therapy;
- Medications administered in excessive duration;
- Adverse medication reactions;
- Medication interactions; and
- Lack of adequate monitoring.

The licensed pharmacist or licensed nurse is responsible for notifying the resident's medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist must notify a licensed nurse within 48 hours of any variance identified in the resident’s regimen review that does not require immediate action by the medical care provider and specify a time within which the licensed nurse must notify the resident’s medical care provider. The licensed nurse is required to seek a response from the medical care provider within five working days of the medical care provider’s notification of a variance.

System inadequacies identified by KDADS survey staff may require a Plan of Correction and further state monitoring. Should noncompliance with regulatory requirements continue, the provider license may be revoked. KDADS Program Managers and MCO are notified at this time so that assistance is available to FE participants. KDHE, the single state Medicaid agency, will be notified during the monthly long-term care meetings until KDADS develops and implements a formal process.

As part of its Quality Assurance for FE waiver participants, KDADS Program Evaluation staff pull a statistically significant random sample of all active FE waiver participants throughout the state on a quarterly basis. Utilizing the state Quality Management Staff (QMS), the State monitors plans of care and care coordination of members on an ongoing basis (at least quarterly and as needed). QMS reviews are conducted by reviewing the member’s Person-Centered Service Plan as well as face to face visits with participants. The state also conducts annual audits of the managed care organizations (MCOs) by reviewing plans of care, all documentation and meeting with the participants.
Utilizing the state Quality Management Staff (QMS), the State monitors plans of care and care coordination of members on an ongoing basis (at least quarterly and as needed). QMS reviews are conducted by reviewing the member’s Person-Centered Service Plan as well as face to face visits with participants. The state also conducts annual audits of the managed care organizations (MCOs) by reviewing plans of care, all documentation and meeting with the participants.

Data gathered by State QMS 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 of Operating Agency for review and approval/denial. KDADS Program Manager and 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.

Critical events including alleged abuse, neglect, and exploitation are reported to the Kansas Department of Children and Families (DCF) APS (APS) (for in-home complaints), KDADS’s Licensure, Certification, and Evaluation (LCE) Commission (for adult care home complaints), and/or law enforcement. Individuals who are considered mandated reporters include care coordinators, administrators, nurses, and home health workers. Notification can occur by phone or written notification to the appropriate entity.

Whenever a quality reviewer encounters an FE 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.

Please refer to Work Plan for enhancements to be added to the operating agency’s Quality Review process and to the reporting, tracking, and trending system. Until the formal process is developed and implemented, KDADS will provide on-going information to the state Medicaid agency during the monthly long-term care meeting.

Non-medical waiver providers may assist participant in medication setup, cuing, and reminding.

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).
Following are excerpts from Assisted Living Facility, Residential Health Care Facility, and Home Plus regulations on self-administration of medications by residents:


1. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.

2. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.

3. If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider’s written order, professional standards or practice, and each manufacturer's recommendations.

4. Non-waiver providers may administer medication in accordance with state laws/regulations that govern their role as delegated under the Nurse Practice Act and nurse delegation. MCOs are responsible for monitoring network providers.

A certified Home Health Aide or Certified Nurse Aide only administer medication to participants with the delegation by a Licensed Nurse. Home Health Aides and Certified Nurse Aides may not perform any acts beyond the scope of their curriculum with the delegation by a Licensed Nurse.

Non-medical resident care facilities are not allowed to provide medication management to FE participants.

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, 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:

Licensed providers are responsible for recording any medication errors.

(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 (KDADS) is the state's licensure and survey agency for adult care homes. An onsite review is completed for each assisted living facility, residential health care facility, and home plus within 15 months of any previous inspection to determine whether the adult care home is complying with applicable statutes, rules, and regulations relating to the health and safety of the residents, including medication administration. Each facility is provided with a survey report, which must be available to the public.

Only licensed nurses and certified medication aides are authorized to administer medications in adult care homes. Medication aides must pass a state-approved course on medication administration, receive a certificate from the KDHE, and be supervised by a licensed nurse. The credentials of these individuals are reviewed as part of the survey process.

During the survey, the KDADS surveyor reviews at least three resident records that may or may not include facility-administered medications to verify that the medications are being administered according to a physician's orders. If applicable, the selected residents' medication regimen reviews are examined to see if the consulting pharmacist identified any concerns within the past year and if so, these concerns were brought to the attention of the resident's medical care provider. Remediation for deficient practices is taken by KDADS through its state enforcement program, which is a progressive system of penalties. Should noncompliance with regulatory requirements continue, the provider license may be revoked. KDADS Program Manager is notified at this time so that assistance is available to FE participants.

These surveys, reviews and remediation protocols, together with others that are part of the MCO contract, are included in a statewide comprehensive QIS 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 IMT, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

Quality Management Staff (QMS) conducts reviews of waiver participants and reports to KDHE on a quarterly basis. In addition, any findings from QMS are reported at monthly Long Term Care (LTC) meetings.

### 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 instances of 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 the appropriate follow-up measures were taken: N = Number of unexpected deaths for which the appropriate follow-up measures were taken, D = Number of unexpected deaths.

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

**Record reviews**

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

| × Continuously and Ongoing |

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| × Other                | × Annually

KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

### Performance Measure:

Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes

\[N = \text{Number of unexpected deaths for which review/investigation resulted in the identification of preventable causes}
\]

\[D = \text{Number of unexpected deaths}\]

### Data Source (Select one):

Other

If ‘Other’ is selected, specify:

**Record reviews**

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- Managed Care Organizations (MCOs)

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### Performance Measure:

- Other Specify:

07/05/2023
Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation. 

\[ N = \text{Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation} \]

\[ D = \text{Number of waiver participants interviewed by QMS staff or whose records are reviewed} \]

**Data Source (Select one):**  
**Other**  
If 'Other' is selected, specify:  
record reviews and Customer Interviews

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Describe Group: |
| | | Proportionate by MCO |
| ✗ Continuously and Ongoing | Other  
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| Other  
Specify: | | |

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- [x] Operating Agency  Monthly
- [x] Sub-State Entity  Quarterly
- Other
  Specify:
  KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

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

- [x] Annually
- Continuously and Ongoing

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures
N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures
D=Number of unexpected deaths

Data Source (Select one):

Other
If 'Other' is selected, specify:

Record reviews

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- [x] Operating Agency
- [ ] Sub-State Entity

Frequency of data collection/generation (check each that applies):

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Sampling Approach (check each that applies):

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- [ ] Representative Sample
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Performance Measures

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

Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures

\[ N \text{= Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures} \]
\[ D \text{= Number of reported critical incidents} \]

Data Source (Select one):
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If ‘Other’ is selected, specify:
Critical incident management system

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**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 participants' reported critical incidents that were initiated and reviewed within required time frames

- **N** = Number of participants' reported critical incidents
- **D** = Number of participants reported critical incidents

**Data Source** (Select one):

- **Other**

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</table>
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

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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

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d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who have a disaster red flag designation with a related disaster red flag designation with a related disaster backup plan
N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
D=Number of waiver participants with a red flag designation

Data Source (Select one):
Other
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Record reviews

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07/05/2023
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Collaboration between the KDADS Field Staff and DCF-APS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with FE waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant’s knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

DCF’s Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Adult Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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

   KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

   DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

   KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

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

   ii. Remediation Data Aggregation

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<td>Sub-State Entity</td>
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c. Timelines

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

☐ No
☐ Yes

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

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).
In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the state’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

### Appendix H: Quality Improvement Strategy (2 of 3)

#### H-1: Systems Improvement

**a. System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.
The Kansas Department of Health and Environment (KDHE), specifically the Division of 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 Home and Community Based Services (HCBS) assurances and minimum standards of service.

The Quality Review 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 Management Specialists collect data from case file reviews. KDADS QMS staff review, compile, and analyze the data obtained as part of the Quality Review process at both the provider and MCO level. This data is aggregated and provided quarterly and to KDHE’s Long-Term Care Committee and the interagency monitoring team, and the KanCare MCOs and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QMS process, other data is captured within the various State systems, the functional eligibility contractor’s systems as well as the MCOs’ systems. On a routine basis, KDADS’ QMS 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 reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency’s critical incident management system. KDADS worked with Adult Protective Services (APS), a division within the Kansas Department for Children and Families (DCF) and the MCOs 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 the Division of Health Care Finance (DHCF) and 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 (AIR) facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS’ Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, QMS 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 QMS 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**

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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.

KDADS and the DHCF within KDHE 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 QMS process. Additional questions may be added to Participant Interview Protocols to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS Case File QMS Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the QMS data and daily program administration, 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 MCO is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS participants and their received services. This participant-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, Program Managers, and QMS 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 DXC and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state’s QIS:

The Operating Agency has developed Quality Management staff and an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (Select one):

☐ No
Yes (Complete item H.2b)

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Based on signed provider agreements, each Home and Community-Based Services (HCBS) provider is required to permit the Kansas Department of Health and Environment (KDHE), the Kansas Department for Aging and Disabilities (KDADS), their designee, and/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 HCBS 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 Managed Care Organizations (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:

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: Aging and Disability Resource Centers (ADRC), Community Mental Health Centers (CMHC), Community Developmental Disability Organizations (CDDO); and Centers for Independent Living (CIL).

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 per member per month payments by the State to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards). The Kancare MCO is responsible for conducting post payment review for payments. The MCO monitors claims payments to ensure members are receiving the services defined in the plan of care. If there were concerns regarding a provider’s billing practice, the MCO would conduct a claims audit which includes requesting provider documentation for services rendered. The MCO has ongoing audits for all services rendered to waiver members. Monthly MCO meetings occur with the MCOs, KDADS and KDHE staff and leadership. At these meetings, any concerns are shared, and follow-up is performed.

Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions (STCs) issued with approval of the related 1915(b) waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements and also a robust evaluation of that demonstration project, which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

Also, these services - as part of the comprehensive KanCare program - will be part of the corporate compliance/program integrity activities of each of the 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 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 (QIS), 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 the Department of Health Care Financing (DHCF) and KDHE 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 DHCF-KDHE staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;

    07/05/2023
b. Provide any and all documentation or information upon request to DHCF-KDHE or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;

c. Report immediately to the DHCF-KDHE, 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 DHCF-KDHE 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 DHCF-KDHE. The duties shall include, but not be limited to the following:

(1) Oversight of the program integrity functions 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 DHCF-KDHE and other agencies concerning program integrity issues.

The State makes payment to the MCO based on the eligibility category assigned by the eligibility system, KEES. The eligibility file is loaded on a nightly basis to the MMIS. Any changes that occur to the participant’s eligibility are made in KEES, sent to the MMIS, and updated nightly. Capitation payments are made to the MCOs’ retrospectively. The reconciliation process in the MMIS with the 834 will catch the capitation error and recoup against the MCO payment.

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. Only Native American populations can opt out of managed care. These claims could be pulled into a SURS audit. Audits could be conducted by SURS or by a federal entity such as PERM. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider is flagged as an outlier or for questionable billing practices.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered.

For Managed Care, The MCO is responsible for post-payment reviews. The MCO has ongoing audits for all services rendered to waiver members. Monthly MCO meetings occur with the MCOs, KDADS and KDHE staff and leadership. At these meetings, any concerns are shared, and follow-up is performed.

In Kansas, the Division of Legislative Post Audits (LPA) are responsible for the contracting of the single-state audit. The LPA is the non-partisan audit arm of the Kansas Legislature.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States
Methods for Discovery: 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:

Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract

N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract

D=Total number of provider claims

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSS/DAI encounter data

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### KanCare Managed Care Organizations (MCOs)

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KanCare Managed Care Organizations (MCOs) participate in analysis of this measure’s results as determined by the State operating agency

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### 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

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If ‘Other’ is selected, specify:

**DSS/DAI encounter data**

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b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

**Performance Measures**

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

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

**Performance Measure:**

Number and percent of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS throughout the five year renewal cycle. N=number of payment rates that were certified to be actuarially sound by the State' actuary and approved by CMS D=Total number of capitation (payment) rates

**Data Source (Select one):**

Other

If 'Other' is selected, specify:

**Rate-setting documentation**

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state established an inter-agency monitoring to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state QIS for the KanCare program, a key component of which is the interagency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.

**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 MCO contract, are included in a statewide comprehensive QIS which is regularly reviewed and adjusted. That plan is contributed to and monitored through a 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. Results are tracked consistent with the statewide QIS and the operating protocols of the interagency monitoring team.

**ii. Remediation Data Aggregation**

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

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**c. Timelines**

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

- **No**
- **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).
Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The floor rates were last reviewed and revised effective 7/1/19 per State Policy, when a rate adjustment was made effective. The adjustment was made available through legislative appropriation.

The floor rates were last reviewed and revised effective 7/1/19 per State Policy, when a rate adjustment was made effective. The adjustment was made available through legislative appropriation.

Capitation rates are based on actuarial analysis of historical data for all HCBS program services. These rates are set by the state’s contracted actuary and are based on historical claims and utilization. The state provides all appropriate data to the Actuary for the rate setting process.

The State does not currently have a set timeframe for regular reviews of the FFS rates for Waiver services. However, there are periodic checks of the rates and utilization for each of the services on the waiver. The State has leveraged, and will continue to leverage, multiple sources to assist in researching the adequacy of our rates. This would include strategies such as engaging with a consulting group to provide a rate study of surrounding states to benchmark where Kansas rates rank. The State also periodically requests that the MCOs review rates for similar services in other markets that they serve. Additionally, the State has open lines of communication with various provider groups, and welcomes research performed by such groups as another data point. The goal of these studies is to ensure that the rates for waiver services are sufficient to encourage providers to continue serving the waiver population, thus maintaining network adequacy. The agency has discretion to set and adjust the rates as they deem necessary; if the agency determines that a rate change is necessary, they would write a policy to change the fee schedule accordingly. Changing rates does not require legislative authority; however, since the legislature is the only body that can appropriate funds, the agency would need to request funding from the legislature to increase its budget to account for the increased spend associated with a rate change.

The Operating Agency is responsible for rate determination and oversight of the process to ensure actuarially sound methods, including historical claims, are used to determine service rates. Under KanCare, the State sets the floor HCBS service rates which serve as the minimum MCOs are required to pay providers. It should be noted that funding for rate increases requires legislative appropriation in Kansas.

The Operating Agency ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt out from Managed Care. In the event, there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available.

The Operating Agency ensures public comment is available as rate adjustments are dependent on legislative appropriation which each year provides opportunity for public and stakeholder feedback and comments on rates during each legislative process.

https://www.kdads.ks.gov/docs/default-source/csp/hcbs/waiver-renewals/fe/fe-waiver-public-comment-invitation890263ac0172e66d690a7ff00009edf98.pdf?sfvrsn=6b2c05ee_4

FFS rates are publicly available via State Bulletins via the State’s KMAP website.


The KanCare program solicited public input when the program was developed which included the State setting the floor for service rates. Waiver participants can obtain information about reimbursement rates for individual services by contacting their assigned MCO.

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.

Claims are received via electronic or paper media. Electronic claims are separated out between MCO and FFS based on the Beneficiary ID and the first date of service on the claim compared with the eligibility file. The claims, where assignment to an MCO is found for that date of service, are sent to the MCO for processing. Claims without an MCO assignments are processed FFS.

Paper claims are sent back to the provider if it can be determined the beneficiary is assigned to an MCO. Otherwise, the claims are processed through the MMIS and deny if the beneficiary is assigned to an MCO or process through the FFS claims engine if not assigned.

The claims are processed through the claims engine based on the beneficiary’s benefit plan HCBS/FE (HCFE). This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

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

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. Only Native American populations can opt out of managed care.

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

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

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.) Direct Support Workers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation.

In EVV, each Direct Support Worker who has passed the KDADS’ Background Check has a Worker ID associated with a provider agency. Information in EVV explains the list of services the Direct Support Worker is associated with. Any deviation from that service list is noted in an exception on the claim. In order to bill for agency-directed PCS, a provider must be enrolled in KMAP. To enroll in KMAP the agency must submit their Home Health Agency license, which is required for agency-directed PCS. The MCOs verify provider qualifications annually for all HCBS providers.

ii) MCOs submit authorizations to AuthentiCare for services that have been determined necessary by the participant’s functional assessment. Authorizations included the timeline of service delivery, the service to be delivered and the number of units that were determined by the participant’s assessment. All claims for service created by the Check-In and Checkout are subject to the timeline, the service, and the number of service units on the claim. Any claims that do not meet the service, the timeline and/or the number of units for which the participant was assessed are marked with a Critical Exception which will render the provider unable to confirm the claim for export.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):
No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:
A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through the Kansas Eligibility Enforcement System (KEES). The state also is requiring the MCOs to utilize the State’s contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the consumer’s plan of care detailing authorized services. All mandated services must be billed through the EVV system. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1.

Individuals (participants) must be determined to have met the program’s level of care criteria and Medicaid eligible prior to starting services.

Services delivered that are reimbursed through Medicaid payments are only for services that are authorized on the approved Plan of Care and within the service limitations written into the service descriptions.

These claims could be pulled into a SURS audit. Audits could be conducted by SURS. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider is flagged as an outlier or for questionable billing practices.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered. The following process is in place for all HCBS claims that are subject to the EVV system including those paid on a FFS basis.

1. Claims created in the EVV system are subject to provider review and confirmation.
2. Claims can be confirmed if Critical Exceptions do not exist.
3. Confirmed claims are exported to Payers in an 837 claims file.
4. The 837 claims file exports at a set time early the next morning following confirmation. Payers receive claims for adjudication the date following confirmation of claims by providers.

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.

The Medicaid Management Information System (MMIS) verifies an individual is eligible for Medicaid payment on the date of service.

The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS.

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered.

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) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.

FFS providers have the option to be paid via a check or through EFT. Payment is made based on the provider’s preference.

All other claims paid outside of the MMIS system are paid to the MCOs through a per member per month capitated payment. The claim is received and processed through the MMIS Claims Engine. The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment.

The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.
Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent.

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.

In the event an FFS participant chose to Self-Direct their services; those services would be provided by an FMS provider that is enrolled with the Medicaid Program that would act as a limited fiscal agent between the state and the participant/employer.

Providers are paid by a managed care entity or entities for services that are included in the state’s contract with the entity.

Specify how providers are paid for the services (if any) not included in the state’s contract with managed care entities.

All of the waiver services in this program are included in the state’s contract with the MCOs. In the event a FFS participant chose to Self-Direct their services, those services would be provided by an FMS provider that is enrolled with the Medicaid Program that would act as a limited fiscal agent between the state and the participant/employer.

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:

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Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

---

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Any beneficiary that received their services through FFS, the provider would retain 100% of the amount claimed.

---
g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver
and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

- This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

× Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the operating agency. The non-federal share of the waiver expenditures is directly expended by KDADS. Both capitated rates and FFS Medicaid claim payments are processed by the State’s fiscal agent through the MMIS using the InterChange STARS Interface System (iCISIS). iCISIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCISIS’s reporting module to identify payments made by each agency. DHCF-KDHE draws down federal Medicaid funds for all agencies based on the summary reports from iCISIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on FFS claims and capitation payments in the KanCare program.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:
Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

- Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
- Applicable
  
  Check each that applies:

  Appropriation of Local Government Revenues.

  Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  The non-federal share of the waiver expenditures is from direct state appropriations to the operating agency. The non-federal share of the waiver expenditures is directly expended by KDADS. Both capitated rates and FFS Medicaid claim payments are processed by the State's fiscal agent through the MMIS using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. DHCF-KDHE draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on FFS claims and capitation payments in the KanCare program.

Other 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.

The Actuary may collect financial information regarding room and board, the information is excluded from any 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: Nursing Facility

<table>
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<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column 4)</th>
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<td>2719.00</td>
<td>13092.57</td>
<td>30678.00</td>
<td>3716.00</td>
<td>34394.00</td>
<td>21301.43</td>
</tr>
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<td>2719.00</td>
<td>13092.57</td>
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<td>34394.00</td>
<td>21301.43</td>
</tr>
</tbody>
</table>

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:

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<td></td>
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</tr>
</tbody>
</table>
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) estimate is derived from the unduplicated participants and days of waiver enrollment from the approved CMS-372 reports for calendar year 2016. The ALOS was projected by dividing 1,790,247 (days of waiver enrollment) by 6,258 (unduplicated participants). The projected average length of stay for this renewal is 286.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is estimated by using actual MCO encounter data from the Medicaid Management Information System (MMIS) of the Home and Community Based Services waiver service cost and utilization for the Frail Elderly waiver participants. Actual MCO encounter payments were utilized in order to estimate the state cost of Factor D as part of an all-inclusive capitated payment. The MCO encounter data was used to establish the estimated number of users and utilization which was averaged over the three-year period. The state utilized most recent cost per unit data at the time the Waiver renewal was prepared to ensure most current cost data was recognized.

For the waiver renewal period, there is no annual trending applied to the unit cost for Factor D. The State does not currently anticipate that there will be a significant change in rates over the next five years as the rate adjustments are subject to legislative appropriation.

The State cannot use the CMS-372 reports to estimate Factor D because of the difference in reporting methodology between the 372 reports and Appendix J. The CMS-372 report is based on the managed care instructions received from CMS on 1/26/2015.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:
Factor D' is estimated by utilizing actual MCO encounter data for State Plan services from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of utilization and persons served which is trended with most current costs for all services that are furnished in addition to the waiver services while the individual is on the waiver.

For the waiver renewal period, there is no annual trending applied to Factor D'. The State does not currently anticipate that there will be a significant change in rates over the next five years. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

Factor D' estimates do not include the cost of prescribed drugs that are furnished to dual eligible under the provisions of Medicare Part D. This is not a Medicaid cost, and it is not paid through the MMIS.

In Kansas Factor G' has historically been greater than D'. This is primarily attributed to the costs of hospice services being included as part of the State Plan G' services. Approximately 50% of G' costs are attributed to hospice services.

In Kansas Factor G' has historically been greater than D'. This is primarily attributed to the costs of hospice services being included as part of the State Plan G' services. Approximately 50% of G' costs are attributed to hospice services.

The State cannot use the CMS-372 reports to estimate Factor D because of the difference in reporting methodology between the 372 reports and Appendix J. The CMS-372 report is based on the managed care instructions received from CMS on 1/26/2015.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is estimated by utilizing actual MCO encounter data from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of the nursing facility utilization for nursing facility participants which is trended with the most current cost information.

For the waiver renewal period, there is no annual trending applied to Factor G. The State has not included any assumptions that there will be a significant change in institutional costs over the next five years for this population. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

The State cannot use the CMS-372 reports to estimate Factor G because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs. The State used encounter data from the MMIS as the base data in the derivation of Factor G to most accurately represent the cost associated with those served in the institutional equivalent.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:
Factor G’ is estimated by utilizing MCO encounter data from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of utilization and persons served for all other Medicaid services furnished while the individual is institutionalized. The averages are trended with most current cost data.

For the waiver renewal period, there is no annual trending applied to Factor G’. The State does not currently anticipate that there will be a significant change in rates over the next five years. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

Factor G’ estimates do not include the cost of prescribed drugs that are furnished to dual eligibles under the provisions of Medicare Part D. This is not a Medicaid cost, and it is not paid through the MMIS.

In Kansas Factor G’ has historically been greater than D’. This is primarily attributed to the costs of hospice services being included as part of the State Plan G’ services. Approximately 50% of G’ costs are attributed to hospice services.

The State cannot use the CMS-372 reports to estimate Factor G’, because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs. The State used MCO encounters data from the MMIS as the base data in the derivation of Factor G’ to most accurately represent the cost associated with those served in the institutional equivalent.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

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<tr>
<th>Waiver Services</th>
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</thead>
<tbody>
<tr>
<td>Financial Management Services</td>
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<tr>
<td>Adult Day Care</td>
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<tr>
<td>Assistive Services</td>
</tr>
<tr>
<td>Comprehensive Support</td>
</tr>
<tr>
<td>Enhanced Care Service</td>
</tr>
<tr>
<td>Home Telehealth</td>
</tr>
<tr>
<td>Medication Reminder Service/Installation</td>
</tr>
<tr>
<td>Nursing Evaluation Visit</td>
</tr>
<tr>
<td>Oral Health Services</td>
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<tr>
<td>Personal Care Services</td>
</tr>
<tr>
<td>Personal Emergency Response System and Installation</td>
</tr>
<tr>
<td>Wellness Monitoring</td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
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<td>2663519.51</td>
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<td>99933.72</td>
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<td>1 day (&gt; 5 hours)</td>
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GRAND TOTAL: 64917785.17
Total: Services included in capitation: 64917785.17
Total: Services not included in capitation: 64917785.17
Total Estimated Unduplicated Participants: 6258
Factor D (Divide total by number of participants): 10373.57
Services included in capitation: 10373.57
Services not included in capitation: 10373.57
Average Length of Stay on the Waiver: 286
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

- **ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

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<th>Avg. Cost/Unit</th>
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<td>110791.22</td>
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</table>

**GRAND TOTAL:**

4697785.17

Total: Services included in capitation:

4697785.17

Total: Services not included in capitation:

6258

Total Estimated Unduplicated Participants:

6258

Factor D (Divide total by number of participants):

10373.57

Services included in capitation:

10373.57

Services not included in capitation:

Average Length of Stay on the Waiver:

286
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<th>Avg. Cost/Unit</th>
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<td>Financial Management Services</td>
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<td>2392</td>
<td>8.73</td>
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<td>2663519.51</td>
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<td>Adult Day Care Total:</td>
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<tr>
<td>One to Five Hours</td>
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<td>J day (&lt; 5 hrs)</td>
<td>21</td>
<td>212.16</td>
<td>22.43</td>
<td>99933.72</td>
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<td>More than Five Hours</td>
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<td>161.01</td>
<td>42.74</td>
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<tr>
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<tr>
<td>Agency-Directed</td>
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<td>Self-Directed</td>
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<td>2493.52</td>
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<td>Home Telehealth - Installation</td>
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<td>254.42</td>
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<td>103</td>
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**GRAND TOTAL:** 64917771.35
Total: Services included in capitation: 5496420.01
Total: Services not included in capitation: 1804564.33
Total Estimated Unduplicated Participants: 6258
Factor D (Divide total by number of participants): 10373.57
Services included in capitation: 8293.90
Services not included in capitation: 2079.67
Average Length of Stay on the Waiver: 286

07/05/2023
<table>
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<tr>
<th>Waiver Service/ Component</th>
<th>Capitation</th>
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<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Personal Care Services - Agency-Directed - Level I</td>
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<td>15 minutes</td>
<td>351</td>
<td>646.57</td>
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Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

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<th>Avg. Cost/ Unit</th>
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07/05/2023
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<td>1 month</td>
<td>103</td>
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</table>

**GRAND TOTAL:** 6491778.17

Total: Services included in capitation: 6491778.17
Total: Services not included in capitation: 0
Total Estimated Unduplicated Participants: 6258
Factor D (Divide total by number of participants): 10373.57
Average Length of Stay on the Waiver: 286
### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

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<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
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<td>351</td>
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<td>760269.33</td>
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<tr>
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<td>x</td>
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<td>1597</td>
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<td>3.77</td>
<td>13014566.33</td>
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<tr>
<td></td>
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<td>15 minutes</td>
<td>1909</td>
<td>3328.64</td>
<td>3.62</td>
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<td>89.78</td>
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<td>7.67</td>
<td>31.91</td>
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<td>2.35</td>
<td>54.82</td>
<td>110791.22</td>
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**GRAND TOTAL:**

Total: Services included in capitation: 64917785.17

Total: Services not included in capitation: 6258

Total Estimated Unduplicated Participants:

Factor D (Divide total by number of participants):

Services included in capitation: 10373.57

Services not included in capitation: 10373.57

Average Length of Stay on the Waiver: 286

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**Application for 1915(c) HCBS Waiver: Draft KS.006.05.06 - Jan 01, 2024**

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07/05/2023
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<th>Avg. Cost/ Unit</th>
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</table>

**Total Estimated Unduplicated Participants:** 6258

**Factor D (Divide total by number of participants):**

- Services included in capitation: 10373.57
- Services not included in capitation: 13921.68

**Average Length of Stay on the Waiver:** 286
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

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<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
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<td>7.67</td>
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<td>2.35</td>
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**GRAND TOTAL:**

Total: Services included in capitation: 64917785.17
Total: Services not included in capitation: 6258
Factor D (Divide total by number of participants): 10373.57
Services included in capitation: 10373.57
Services not included in capitation: 6258
Average Length of Stay on the Waiver: 286
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<th># Users</th>
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<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<td>U day (&lt; 5 hrs)</td>
<td>21</td>
<td>212.16</td>
<td>22.43</td>
<td>99933.72</td>
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<tr>
<td>More than Five Hours</td>
<td>X</td>
<td>U day (&gt; 5 hours)</td>
<td>29</td>
<td>161.01</td>
<td>42.74</td>
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<td></td>
<td></td>
<td></td>
<td>187816.44</td>
</tr>
<tr>
<td>Assistive Services</td>
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<td>U purchase</td>
<td>73</td>
<td>1.23</td>
<td>2091.73</td>
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<tr>
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<td>30</td>
<td>2176.04</td>
<td>4.17</td>
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<tr>
<td>Self-Directed</td>
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<td>10541.30</td>
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<td>U day</td>
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<td>254.42</td>
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<td>321625.04</td>
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<td>13921.68</td>
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<td>Medication Reminder Service/Installation</td>
<td>X</td>
<td>U month</td>
<td>103</td>
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<td>U visit</td>
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<td>1.00</td>
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<td></td>
</tr>
<tr>
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<td>351</td>
<td>646.57</td>
<td>3.35</td>
<td>760269.33</td>
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</tr>
</tbody>
</table>

**GRAND TOTAL:** 64947785.17
Total: Services included in capitation: 64917785.17
Total: Services not included in capitation: 6258
Total Estimated Unduplicated Participants: 18373.57
Factor D (Divide total by number of participants): 10373.57
Services included in capitation: 10373.57
Services not included in capitation: 280

Average Length of Stay on the Waiver: 07/05/2023
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<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Services - Agency-Directed - Level II</td>
<td>15 minutes</td>
<td>1597</td>
<td>1597</td>
<td>2161.64</td>
<td>3.77</td>
<td>13014564.33</td>
<td>13014564.33</td>
</tr>
<tr>
<td>Personal Care Services - Agency-Directed - Level III</td>
<td>15 minutes</td>
<td>1909</td>
<td>1909</td>
<td>3328.64</td>
<td>3.62</td>
<td>23002833.01</td>
<td>23002833.01</td>
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<tr>
<td>Personal Emergency Response System and Installation Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>745328.16</td>
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<tr>
<td>Personal Emergency Response - Installation</td>
<td>1 installation</td>
<td>426</td>
<td>426</td>
<td>1.00</td>
<td>89.78</td>
<td>38246.28</td>
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</tr>
<tr>
<td>Personal Emergency Response - Rental</td>
<td>1 month</td>
<td>2889</td>
<td>2889</td>
<td>7.67</td>
<td>31.91</td>
<td>707081.88</td>
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<td>Wellness Monitoring Total:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>110791.22</td>
<td>110791.22</td>
</tr>
<tr>
<td>Wellness Monitoring</td>
<td>1 visit</td>
<td>860</td>
<td>860</td>
<td>2.35</td>
<td>54.82</td>
<td>110791.22</td>
<td>110791.22</td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

Total: Services included in capitation: 64917785.17

Total: Services not included in capitation: 64917785.17

Total Estimated Unduplicated Participants: 6258

Factor D (Divide total by number of participants): 10373.57

Services included in capitation: 10373.57

Services not included in capitation: 10373.57

Average Length of Stay on the Waiver: 286
Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

   A. The State of Kansas requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
   
   B. Program Title:
      Kansas - HCBS-I/DD Waiver
   
   C. Waiver Number: KS.0224
      Original Base Waiver Number: KS.0224.
   
   D. Amendment Number:

   E. Proposed Effective Date: (mm/dd/yy)
      01/01/24

   Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

   To align this waiver with the submission of the State's 1915(b) application.

3. Nature of the Amendment

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

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Application</td>
<td></td>
</tr>
<tr>
<td>Appendix A</td>
<td></td>
</tr>
<tr>
<td>Waiver Administration and Operation</td>
<td></td>
</tr>
<tr>
<td>Appendix B</td>
<td></td>
</tr>
<tr>
<td>Component of the Approved Waiver</td>
<td>Subsection(s)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Participant Access and Eligibility</td>
<td></td>
</tr>
<tr>
<td>Appendix C Participant Services</td>
<td></td>
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<tr>
<td>Appendix D Participant Centered Service Planning and Delivery</td>
<td></td>
</tr>
<tr>
<td>Appendix E Participant Direction of Services</td>
<td></td>
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<tr>
<td>Appendix F Participant Rights</td>
<td></td>
</tr>
<tr>
<td>Appendix G Participant Safeguards</td>
<td></td>
</tr>
<tr>
<td>Appendix H</td>
<td></td>
</tr>
<tr>
<td>Appendix I Financial Accountability</td>
<td></td>
</tr>
<tr>
<td>Appendix J Cost-Neutrality Demonstration</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

1. Request Information (1 of 3)

   A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (optional - this title will be used to locate this waiver in the finder):

Kansas - HCBS-I/DD Waiver

C. Type of Request: amendment

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

☑ 3 years  ☐ 5 years

Original Base Waiver Number: KS.0224
Draft ID: KS.008.06.05

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19
Approved Effective Date of Waiver being Amended: 07/01/19

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☒ Hospital
Select applicable level of care

☐ Hospital as defined in 42 CFR §440.10
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility
Select applicable level of care

☐ Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

07/05/2023
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
- [x] Applicable

Check the applicable authority or authorities:

- [x] Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
- [x] 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:

This amendment is being submitted simultaneously with the 1915(b) application.

Specify the §1915(b) authorities under which this program operates (check each that applies):

- [x] §1915(b)(1) (mandated enrollment to managed care)
- [x] §1915(b)(2) (central broker)
- [x] §1915(b)(3) (employ cost savings to furnish additional services)
- [x] §1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.
A program authorized under §1915(j) of the Act.
A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:
This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

The 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 inpatients of a hospital, nursing facility or ICF/IID.

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

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

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

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

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

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

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

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

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

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
8. Authorizing Signature

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

Signature: 

State Medicaid Director or Designee

Submission Date: 

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

Last Name: 
First Name: 
Title: 
Agency: 
Address: 
Address 2: 
City: 
Phone: (785) 296-0648 
Ext: 
TTY 
Fax: (785) 296-0256 
E-mail: paula.morgan@ks.gov

07/05/2023
Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

This amendment will create no negative impact on waiver participants.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

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

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

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.
The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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
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 1915(b) 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.

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant waiver enrollment</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiver enrollment managed against approved limits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiver expenditures managed against approved levels</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of care evaluation</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Review of Participant service plans</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prior authorization of waiver services</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization management</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Qualified provider enrollment</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Execution of Medicaid provider agreements</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Establishment of a statewide rate methodology</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rules, policies, procedures and information development governing the waiver program</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Quality assurance and quality improvement activities</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid

07/05/2023
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

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<th>Frequency of data collection/generation</th>
<th>Sampling Approach (check each that applies):</th>
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</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
<td>Representative Sample</td>
</tr>
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<td></td>
<td>Confidence</td>
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<td>Annually</td>
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<td>× Continuously and Ongoing</td>
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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

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<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>Sub-State Entity</td>
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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 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:

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Data Aggregation and Analysis:

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<td>× Continuously and Ongoing</td>
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<td>Other Specify:</td>
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</table>

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

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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>× Operating Agency</td>
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<td>Sub-State Entity</td>
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<td>Annually</td>
</tr>
<tr>
<td>× Continuously and Ongoing</td>
<td>Other Specify:</td>
</tr>
</tbody>
</table>
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 priority 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.

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

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

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

   KDHE and KDADS have a process in place to ensure all waiver amendments are reviewed and approved prior to submission to CMS. KDHE has ultimate responsibility for submitting waiver renewals and amendment to CMS.

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

<table>
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<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
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<tr>
<td>Other Specify:</td>
<td>Annually</td>
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</table>
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:

<table>
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<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
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<td>Aged Disabled, or Both - General</td>
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<td>Aged</td>
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<tr>
<td>Disabled (Other)</td>
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<td>Aged Disabled, or Both - Specific Recognized Subgroups</td>
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<tr>
<td>Brain Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Fragile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability or Developmental Disability, or Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Disability</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

Qualifying IDD waiver applicants have either an ID that began before age 18 OR a DD that began before age 22.

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:
O 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.

O 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. 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:


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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>9491</td>
</tr>
<tr>
<td>Year 2</td>
<td>9491</td>
</tr>
<tr>
<td>Year 3</td>
<td>9491</td>
</tr>
<tr>
<td>Year 4</td>
<td>9491</td>
</tr>
<tr>
<td>Year 5</td>
<td>9491</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served at Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>9111</td>
</tr>
<tr>
<td>Year 2</td>
<td>9111</td>
</tr>
<tr>
<td>Year 3</td>
<td>9111</td>
</tr>
<tr>
<td>Year 4</td>
<td>9111</td>
</tr>
<tr>
<td>Year 5</td>
<td>9111</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Institutional Stay</td>
</tr>
<tr>
<td>Children coming into the custody of the Department of Children and Families (DCF)</td>
</tr>
<tr>
<td>Children determined to be no longer eligible for the Autism (AU) Waiver</td>
</tr>
<tr>
<td>WORK Program Transitions</td>
</tr>
<tr>
<td>Participants determined to be no longer eligible for the Brain Injury (BI) waiver</td>
</tr>
<tr>
<td>HCBS Institutional Transitions</td>
</tr>
<tr>
<td>Children determined to be no longer eligible for the Technology Assisted (TA) waiver</td>
</tr>
<tr>
<td>Military Inclusion</td>
</tr>
</tbody>
</table>

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:

The amount of reserved capacity was determined by historical data regarding the average number of participants who have been admitted for Temporary Institutional Stays.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>50</td>
</tr>
<tr>
<td>Year 2</td>
<td>50</td>
</tr>
<tr>
<td>Year 3</td>
<td>50</td>
</tr>
<tr>
<td>Year 4</td>
<td>50</td>
</tr>
<tr>
<td>Year 5</td>
<td>50</td>
</tr>
</tbody>
</table>

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:
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:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>10</td>
</tr>
<tr>
<td>Year 2</td>
<td>10</td>
</tr>
<tr>
<td>Year 3</td>
<td>10</td>
</tr>
<tr>
<td>Year 4</td>
<td>10</td>
</tr>
<tr>
<td>Year 5</td>
<td>10</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>45</td>
</tr>
<tr>
<td>Year 2</td>
<td>45</td>
</tr>
<tr>
<td>Year 3</td>
<td>45</td>
</tr>
<tr>
<td>Year 4</td>
<td>45</td>
</tr>
<tr>
<td>Year 5</td>
<td>45</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>15</td>
</tr>
<tr>
<td>Year 2</td>
<td>15</td>
</tr>
<tr>
<td>Year 3</td>
<td>15</td>
</tr>
<tr>
<td>Year 4</td>
<td>15</td>
</tr>
<tr>
<td>Year 5</td>
<td>15</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>
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 KDADS Working Healthy/WORK policy identifies the process for individuals to access the IDD waiver from the WORK program.
6. The BI Transition policy identifies the process for eligible individuals to transition from the BI waiver to the IDD waiver.
7. All future access to the HCBS waiver will be determined on a first-come-first-serve basis based on each person’s requested date for service.
8. For those persons who are determined to be in crisis or imminent risk of crisis, and whose needs can only be met through services available through the IDD waiver, these persons will have immediate access to services, subject to their assessed needs for services, based on the criteria established in the Crisis and Exception policy.
9. Per Kansas Crisis and Exception Policy E2016-119, all persons requesting access to HCBS-IDD waiver program services must meet IDD eligibility standards and functional eligibility requirements. Functional Eligibility Assessments and Waitlist Management policy E2017-034 explains the process, procedures, and requirements for assessors, assessment entry timeframes, quality assurance and reporting, and IDD waitlist management.
10. All requests for crisis or exception access to the HCBS-IDD waitlist will be made through the CDDO in the area in which the person resides. Prior to submission of a crisis or exception request, the person must have a current functional eligibility assessment performed within the past 365 days that indicates functional eligibility.

Crisis Access:

Persons are determined to be in crisis under the following conditions:
1. Documentation from law enforcement or DCF support the need for the person’s protection from confirmed abuse, neglect, or exploitation.
2. Documentation substantiating that the person is at significant, imminent risk, and is capable of performing serious harm to self or others.

The CDDOs are responsible for providing all supporting documentation necessary for the State to render a determination for a crisis request. Administration Reconsideration and Appeal Rights are provided in the event of a KDADS denial outcome.

Exception Access:

Exception access may be provided to a person in the following situations:
1. Persons in the custody of the Department of Children and Families (DCF) for the purpose of addressing non-supervision support needs related specifically to the person’s IDD diagnosis. Services in this case shall not duplicate services already being provided, or services that should be provided by the foster parent.
2. Persons who have been determined to be at imminent risk of coming into DCF custody. Exception access in this case would be to assure that the person avoids DCF custody. DCF or court documentation would be required to justify this exception.
3. Persons under the age of 18 who are transitioning from DCF custody. DCF or court documentation is required to justify this exception.
4. Persons 18 years old and older who are transitioning from DCF custody. DCF or court documentation is required to justify this exception.
5. Persons who have successfully transitioned from Vocational Rehabilitation Services (VRS) who require on-going support to maintain employment and self-sufficiency. Documentation of a successful VRS case closure indicating a need for continued supports is required in order to justify this exception.
6. Persons meeting the criteria set for in the KDADS ‘Military Inclusion’ policy M2015-132. Documentation requirements include a DD 214 form, TriCare Echo verification, and proof of residency.
7. Persons previously on the IDD waiver transferring back to the IDD waiver from the WORK program.
8. Persons meeting the criteria established in the HCBS Institutional Transition Policy M2018-119, and who also meet IDD program and functional eligibility criteria, if coming out of an approved institutional setting minimum stay of ninety (90) consecutive days prior to applying for an institutional transition, can by-pass the IDD waiver waitlist, and be immediately placed on IDD waiver services.

Transitions from other waivers:
The following HCBS programs shall transition to the IDD waiver program if they meet IDD waiver program and functional eligibility:
1. Persons determined no longer eligible for the Brain Injury waiver;
2. Persons determined no longer eligible for the Technology Assisted waiver
3. Children determined no longer eligible for the Autism waiver.
4. Upon approval from KDADS, an exception can be made when it is determined that the IDD waiver is the most appropriate considering the person’s health and safety.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (select one):
   - §1634 State
   - SSI Criteria State
   - 209(b) State

2. Miller Trust State.
   Indicate whether the state is a Miller Trust State (select one):
   - No
   - Yes

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

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

   - Low income families with children as provided in §1931 of the Act
   - SSI recipients
   - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
   - Optional state supplement recipients
   - Optional categorically needy aged and/or disabled individuals who have income at:
     Select one:
     - 100% of the Federal poverty level (FPL)
     - % of FPL, which is lower than 100% of FPL.
     Specify percentage: [ ]
   - Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
   - Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility
group as provided in §1902(e)(3) of the Act
Medically needy in 209(b) States (42 CFR §435.330)
× Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
× Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Parents and other caretaker relatives (42 CFR 435.110; 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:

× A special income level equal to:

Select one:

☐ 300% of the SSI Federal Benefit Rate (FBR)
☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage: 

☐ A dollar amount which is lower than 300%.

Specify dollar amount:

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

× Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
Medically needy without spend down in 209(b) States (42 CFR §435.330)
Aged and disabled individuals who have income at:

Select one:

☐ 100% of FPL
☐ % of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)
Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

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

× Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ The following standard included under the state plan
Select one:
- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):
- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%
  Specify the percentage: 
- A dollar amount which is less than 300%.
  Specify dollar amount: 
- A percentage of the Federal poverty level
  Specify percentage: 
- Other standard included under the state Plan
  Specify:
  
- The following dollar amount
  Specify dollar amount: If this amount changes, this item will be revised.

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

- Other
  Specify:

---

ii. Allowance for the spouse only (select one):
- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
  Specify:
Specify the amount of the allowance (select one):

- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The following dollar amount:

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

- The amount is determined using the following formula:

  Specify:

iii. Allowance for the family (select one):

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

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

- The amount is determined using the following formula:

  Specify:

- Other

  Specify:

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

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

Select one:

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

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

○ The following dollar amount:

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

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

Specify formula:

○ Other
Specify:

300% of SSI

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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


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.


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.

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- Other
  Specify:

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

The Developmental Disability Profile (DDP) is the tool that is used to determine functional eligibility for the IDD waiver. Eligibility is based on the following categories Adaptive, Maladaptive and Health categories.

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 subcontract 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.

Kansas began a new stakeholder engagement process in summer 2019 to enhance several HCBS waiver programs, including the I/DD waiver. The stakeholder re-engagement period will focus on improving waiver service delivery, ensuring waiver participant freedom of choice, and supporting community inclusion. Changes to the waivers resulting from the stakeholder re-engagement process will be implemented via forthcoming amendments.

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

\[ N = \text{Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services} \]
\[ D = \text{Total number of enrolled waiver participants} \]

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

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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 Management Information System (KAMIS) or related web applications.

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**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:

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*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

\[ N = \text{Number of waiver participants whose Level of Care determinations used the approved screening tool} \]
\[ D = \text{Number of waiver participants who had a Level of Care determination} \]

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

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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

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### Performance Measure:

Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor

\[ N = \text{Number of initial Level of Care (LOC) determinations made by a qualified assessor} \]

\[ D = \text{Number of initial Level of Care determinations} \]

### Data Source (Select one):

- **Other**
  - If 'Other' is selected, specify:
    - Assessor and Assessment Records

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### Application for 1915(c) HCBS Waiver: Draft KS.008.06.05 - Jan 01, 2024 Page 54 of 253

07/05/2023
Data Aggregation and Analysis:

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<td></td>
</tr>
<tr>
<td>Other Specify:</td>
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</table>

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)
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:
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Day Supports</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Overnight Respite Care</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Personal Care Service</td>
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<tr>
<td>Statutory Service</td>
<td>Residential Supports</td>
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<td>Statutory Service</td>
<td>Supported Employment</td>
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<tr>
<td>Supports for Participant Direction</td>
<td>Financial Management Services (FMS)</td>
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<td>Other Service</td>
<td>Assistive Services</td>
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<td>Other Service</td>
<td>Enhanced Care Service</td>
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<td>Other Service</td>
<td>Medical Alert Rental</td>
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<td>Other Service</td>
<td>Specialized Medical Care</td>
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<td>Other Service</td>
<td>Wellness Monitoring</td>
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</table>

**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)

**Service Definition (Scope):**  
**Category 4:**  
04 Day Services  
Sub-Category 4:  
04070 community integration
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.

In order to align this waiver service with federal requirements, the state will complete system changes to unbundle Day Supports and submit a waiver amendment no later than May 2020 in accordance with the timeline agreed upon with CMS.

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.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

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.
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
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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<th>Provider Category</th>
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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:

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<td>08030 personal care</td>
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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, by a parent of a participant who is a minor child under eighteen years of age, or by the unpaid primary caregiver. 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.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

**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:**

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**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:**
Overnight Respite Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

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:

Provider Type:

Overnight Respite Care Provider

Provider Qualifications

License (specify):

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.

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

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Service Type:

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Alternate Service Title (if any):

Personal Care Service

HCBS Taxonomy:

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<td>08030 personal care</td>
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<td>09012 respite, in-home</td>
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</table>

<table>
<thead>
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<th>Sub-Category 4:</th>
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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.
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. Homemaker/chore services provided as part of PCS can only be incidental, and cannot comprise the entirety of the service. PCS performed should be specific to the needs of the waiver recipient as reflected in the personal care service plan.

Laundry:
The waiver participant has documented incontinence issues creating excessive laundry. PCS shall only be authorized for the time spent providing assistance with the participant’s excessive laundry.

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.

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

The services under the IDD waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. PCS is limited to those services 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.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

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):

- 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Individual Personal Assistants</td>
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<tr>
<td>Agency</td>
<td>Home Health Agency</td>
</tr>
</tbody>
</table>

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).

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

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<th>Provider Category:</th>
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<tr>
<td>Agency</td>
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<table>
<thead>
<tr>
<th>Provider Type:</th>
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<tbody>
<tr>
<td>Home Health Agency</td>
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</table>

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.

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.

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:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
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<td></td>
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</table>
Service Definition (Scope):

Adult Residential 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. 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.

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.

Adult Residential Supports may be provided in one of the following ways:
1. a participant lives in his or her own home or apartment without an individual meeting the definition of family or a service provider
2. a participant lives in his or her own home or apartment with other individuals who do not meet the definition of family or a service provider

Adult Residential Supports may be provided in a licensed Group Home or Shared Living Setting.

Children’s Residential Supports provide direct assistance to participants 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 avoid placement in an institution, congregate residential setting or DCF custody when the participant cannot remain in their natural family home.

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 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.

Kansas began a new stakeholder engagement process in summer 2019 to enhance several HCBS waiver programs, including the I/DD waiver. The stakeholder re-engagement period will focus on improving waiver service delivery, ensuring waiver participant freedom of choice, and supporting community inclusion. Changes to the waivers resulting from the stakeholder re-engagement process will be implemented via forthcoming amendments.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Residential Supports cannot be provided in the participant’s family home.

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. 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, Adult and Child Residential Habilitation is limited to those services not covered through EPSDT, the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan. Participants of Adult and Child Residential Supports cannot also receive Personal Care Services, Overnight Respite, or Enhanced Care Services (ECS).

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 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 cannot be provided in a home where more than two participants funded with State or Medicaid money reside.

For the provider to bill the daily rate for residential supports, the participant must have received a residential support service on the date that the provider is billing for. 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.

**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:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Licensed Residential Support Provider</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

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

**Service Type:** Statutory Service  
**Service Name:** Residential Supports

**Provider Category:**

07/05/2023
Agency
Provide Type:

Licensed Residential Support 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 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.
*Must 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
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 workforce. 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
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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</table>

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 Supported Employment 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 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 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.
* Enrolled KMAP provider
* Contract with A MCO or be an approved out-of-network provider

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:**

**Support 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:**

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<td>12 Services Supporting Self-Direction</td>
<td>12010 financial management services in support of self-direction</td>
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<td>12020 information and assistance in support of self-direction</td>
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<tr>
<td>Service Definition (Scope):</td>
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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
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):

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Financial Management Services Provider</td>
</tr>
</tbody>
</table>

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:
Financial Management Services Provider

Provider Qualifications
License (specify):
Not applicable
Certificate (specify):
Not applicable
Other Standard (specify):
Enrolled FMS providers will furnish FMS according to Kansas model.

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 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:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Equipment, Technology, and Modifications</td>
<td>14020 home and/or vehicle accessibility adaptations</td>
</tr>
</tbody>
</table>

**Category 2:**

<table>
<thead>
<tr>
<th>Sub-Category 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>14031 equipment and technology</td>
</tr>
</tbody>
</table>

**Category 3:**

<table>
<thead>
<tr>
<th>Sub-Category 3:</th>
</tr>
</thead>
</table>

**Service Definition (Scope):**

**Category 4:**

<table>
<thead>
<tr>
<th>Sub-Category 4:</th>
</tr>
</thead>
</table>
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. In order to align this waiver service with federal requirements, the state will complete system changes to unbundle Assistive Services and submit a waiver amendment no later than May 2020 in accordance with the timeline agreed upon with CMS.

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.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Modification: Center for Independent Living</td>
</tr>
<tr>
<td>Agency</td>
<td>DME: Durable Medical Equipment Provider, Home Health Agency, Pharmacy, Rural Health Clinic, and Welding Shop</td>
</tr>
</tbody>
</table>

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:
Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

CIL requirements:
Medicaid-enrolled provider
Affiliated with the CDDO

General Contractor requirements:
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.

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):
Rural Health Clinic Certification

Other Standard *(specify):*

1. Medicaid-enrolled provider
2. Affiliated with the CDDO

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

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

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:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 Home-Based Services</td>
<td>08030 personal care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>09 Caregiver Support</td>
<td>09012 respite, in-home</td>
</tr>
</tbody>
</table>
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. 1 unit of service is equal to 6-12 hours 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. 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).
4. 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.

ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest is mitigated as described in C.2.e.

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.

---

**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:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Individual ECS provider</td>
</tr>
<tr>
<td>Agency</td>
<td>Home Health Agency</td>
</tr>
</tbody>
</table>

---

**Appendix C: Participant Services**
Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:
Individual

Provider Type:
Individual ECS provider

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):**

<table>
<thead>
<tr>
<th>Home Health Agency License</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees of a Home Health Agency as specified in K.A.S. 65-5101 through K.S.A. 65-5117.</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Other Service</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Equipment, Technology, and Modifications</td>
<td>14010 personal emergency response system (PERS)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category 3:</th>
<th>Sub-Category 3:</th>
</tr>
</thead>
</table>

Service Definition (Scope):
Category 4:  

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):
- [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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Emergency Transportation Provider</td>
</tr>
<tr>
<td>Agency</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

07/05/2023
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):
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:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 Nursing</td>
<td>05010 private duty nursing</td>
</tr>
</tbody>
</table>

| Category 2: | Sub-Category 2: |
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.

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.

This waiver service is only provided to individuals age 21 and over. All medically necessary Specialized Medical Care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Specialized Medical Care is limited to those services 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. 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.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.
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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Health Agency</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Specialized Medical Care

**Provider Category:**

<table>
<thead>
<tr>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency</td>
</tr>
</tbody>
</table>

**Provider Type:**

| Home Health Agency |

**Provider Qualifications**

**License (specify):**

1. A licensed LPN or RN by the Kansas State Board of Nursing.

**Certificate (specify):**

**Other Standard (specify):**

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:**

07/05/2023
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:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Other Health and Therapeutic Services</td>
<td>11010 health monitoring</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Other Health and Therapeutic Services</td>
<td>11020 health assessment</td>
</tr>
</tbody>
</table>

Service Definition (Scope):

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
</table>
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.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

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
- × Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:
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:
Registered Nurse employed by a licensed HHA or Public Health Department

Provider Qualifications
License (specify):
1. An RN licensed by the Kansas Department of Health and Environment consistent with K.S.A. 65-5101 through K.S.A. 65-5117, AND
2. An employee of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117 OR
3. An employee of a Public Health Department

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 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: Summary of Services Covered (2 of 2)

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

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

Check each that applies:
As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

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

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

As an administrative activity. Complete item C-1-c.

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

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

<table>
<thead>
<tr>
<th>Targeted Case Managers (TCM):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. are licensed by KDADS</td>
</tr>
<tr>
<td>2. are required to contract with the MCOs</td>
</tr>
<tr>
<td>3. are required to be enrolled Medicaid providers for Developmental Disabilities Targeted Case Management services</td>
</tr>
<tr>
<td>4. are required to affiliate with the CDDO in their area</td>
</tr>
</tbody>
</table>

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 Person-Centered 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 I/DD waiver services. This is a part of the MCOs’ administrative functions around care management and participant support within the KanCare program. The work of the MCO staff will supplement the effort of the participant’s IDD waiver and TCM providers.

Kansas began a new stakeholder engagement process in summer 2019 to enhance several HCBS waiver programs, including the I/DD waiver. The stakeholder re-engagement period will focus on improving waiver service delivery, ensuring waiver participant freedom of choice, and supporting community inclusion. Changes to the waivers resulting from the stakeholder re-engagement process will be implemented via forthcoming amendments.

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 all HCBS providers shall perform background checks in accordance with the KDADS’ Background Check policy, and shall comply with all regulations related to Abuse, Neglect and Exploitation.

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

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

The employer shall submit a request for the following checks:
1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver’s license record check through the Kansas Department of Revenue (KDOR)
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)

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

- No. The state does not conduct abuse registry screening.
- Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

CDDOs, CSPs, and all HCBS providers shall perform background checks in accordance with the KDADS’ Background Check policy.

All HCBS providers are required to pass DCF abuse registry checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

CDDOs and CSPs, and all HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. CDDOs, CSPs and all HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, 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.

All HCBS providers are required to pass ANE checks conducted by the following entities.
1. a check for ANE through the Nurse Aid Registry
2. an adult and child ANE check through Department of Children and Families (DCF)
Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Foster Care Setting

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Alert Rental</td>
<td></td>
</tr>
<tr>
<td>Overnight Respite Care</td>
<td>✗</td>
</tr>
<tr>
<td>Financial Management Services (FMS)</td>
<td></td>
</tr>
<tr>
<td>Residential Supports</td>
<td>✗</td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Care</td>
<td>✗</td>
</tr>
<tr>
<td>Personal Care Service</td>
<td>✗</td>
</tr>
<tr>
<td>Assistive Services</td>
<td></td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td>✗</td>
</tr>
<tr>
<td>Wellness Monitoring</td>
<td></td>
</tr>
<tr>
<td>Day Supports</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>✗</td>
</tr>
<tr>
<td>Physical environment</td>
<td>✗</td>
</tr>
<tr>
<td>Sanitation</td>
<td>✗</td>
</tr>
<tr>
<td>Safety</td>
<td>✗</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td>✗</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✗</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✗</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✗</td>
</tr>
</tbody>
</table>
Standard | Topic Addressed
--- | ---
Medication administration | ✗
Use of restrictive interventions | ✗
Incident reporting | ✗
Provision of or arrangement for necessary health services | ✗

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Group Home

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Alert Rental</td>
<td></td>
</tr>
<tr>
<td>Overnight Respite Care</td>
<td></td>
</tr>
<tr>
<td>Financial Management Services (FMS)</td>
<td></td>
</tr>
<tr>
<td>Residential Supports</td>
<td>✗</td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Care</td>
<td></td>
</tr>
<tr>
<td>Personal Care Service</td>
<td></td>
</tr>
<tr>
<td>Assistive Services</td>
<td></td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td></td>
</tr>
<tr>
<td>Wellness Monitoring</td>
<td></td>
</tr>
<tr>
<td>Day Supports</td>
<td></td>
</tr>
</tbody>
</table>

Facility Capacity Limit:

8

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>✗</td>
</tr>
<tr>
<td>Physical environment</td>
<td>✗</td>
</tr>
<tr>
<td>Sanitation</td>
<td>✗</td>
</tr>
<tr>
<td>Safety</td>
<td>✗</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td>✗</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✗</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✗</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✗</td>
</tr>
<tr>
<td>Medication administration</td>
<td>✗</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>✗</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>✗</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✗</td>
</tr>
</tbody>
</table>

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

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

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

The legal guardian or DPOA of an adult participant may provide, whenever the relative/legal guardian is qualified to provide Personal Care Service (PCS), self-directed (PCS) as specified in Appendix C-3.

Since it is the intention of Overnight Respite to provide relief for the participant's family member who serves as an unpaid primary caregiver, the unpaid primary caregiver cannot be paid to provide Respite. Waiver services are not intended to provide care and supervision of minor children. Parents and legal guardians may provide services to minor children if mitigated by the courts and have a designated representative. PCS is for those services above regular care and supervision.

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/legal guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.
The State of Kansas does not prevent non-legally responsible relatives from providing PCS and ECS services. The non-legally responsible relative is subject to the same requirements as detailed in the service definition and provider qualifications in Appendix C.

Services that may be furnished by a relative or legal guardian are limited to the scope, duration and amount determined by the MCO needs assessment and authorized in the participants’ Person-Centered Service Plan.

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.

Since it is the intention of Overnight Respite to provide relief for the participant’s family member who serves as an unpaid primary caregiver, the unpaid primary caregiver cannot be paid to provide Respite.

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

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

Other policy.

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

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

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

   \[ \frac{N}{D} \]

   \(N=\)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
<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
<td>100% Review</td>
</tr>
<tr>
<td>✗ Operating Agency</td>
<td>Monthly</td>
<td>✗ Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
<td>✗ Representative Sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence Interval = 95%</td>
</tr>
<tr>
<td>✗ Other</td>
<td>✗ Annually</td>
<td>✗ Stratified</td>
</tr>
<tr>
<td>Specify:</td>
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<td>Describe Group:</td>
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<td></td>
<td>Proportionate by MCO</td>
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<tr>
<td>✗ Other</td>
<td>✗ Continuously and Ongoing</td>
<td>Other</td>
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<td>Specify:</td>
<td></td>
<td>Specify:</td>
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</table>

**Data Aggregation and Analysis:**

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<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
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</thead>
<tbody>
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<tr>
<td>✗ Operating Agency</td>
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Responsible Party for 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

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

- 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

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

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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

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency.

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 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):
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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**

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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.

### 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.

### Remediation Data Aggregation

07/05/2023
Remediation-related Data Aggregation and Analysis (including trend identification)

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**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.

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**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)

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:*

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.

Appendix D: Participant-Centered Planning and Service Delivery
D-1: Service Plan Development (4 of 8)

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

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

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

b) All applicants for program services must undergo a functional eligibility assessment to determine functional eligibility for the IDD waiver. The DDP is utilized to determine the level of care (LOC) eligibility for the IDD waiver. The CDDO conducts an assessment of the individual within the timeframe specified in the contract, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant that will identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant with assistance from the TCM will complete a Person-Centered Support Plan (Support Plan). The Support Plan is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the Support Plan with the individual and their legal representative during the Service Plan meeting and will use the Support Plan to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

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

d) Through the various assessments and Service Plan related documents described in b) above, the participant’s goals, needs and preferences are at the forefront of developing their Service Plan. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the IDD Person-Centered Service Plan policy.

e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS’ IDD Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan.

f) The responsibilities for implementing and monitoring delivery of services as authorized in the Service Plan are
detailed in the IDD Person-Centered Service Plan policy and the HCBS Quality Review Policy. The participant’s TCM monitors progress toward achieving the goals in the Person-Centered Service Plan. The TCM will make referrals for additional resources as needed. If there is a change in need, the TCM coordinates with the MCO to update and revise the Person-Centered Service Plan. The MCO Care Coordinator monitors delivery of the services authorized in the Person-Centered service plan through a series of face-to-face visits and phone calls.

g) The requirements for how and when the Service Plan are updated are specified in the KDADS’ IDD Person-Centered Service Plan policy. The MCOs conduct periodic reviews, as specified by the KanCare MCO contracts, to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the IDD Person-Centered Service Plan policy.

Kansas began a new stakeholder engagement process in summer 2019 to enhance several HCBS waiver programs, including the I/DD waiver. The stakeholder re-engagement period will focus on improving waiver service delivery, ensuring waiver participant freedom of choice, and supporting community inclusion. Changes to the waivers resulting from the stakeholder re-engagement process will be implemented via forthcoming amendments.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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**Performance Measure:**
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment

\[ N = \text{Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment} \]

\[ D = \text{Number of waiver participants whose service plans were reviewed} \]

**Data Source (Select one):**
- **Other**
  - If 'Other' is selected, specify:
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### Performance Measure:

Number and percent of waiver participants whose service plans address participants' goals

\[ N = \text{Number of waiver participants whose service plans address participants' goals} \]

\[ D = \text{Number of waiver participants whose service plans were reviewed} \]
**Data Source** (Select one):
- **Other**
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Describe Group:  
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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

\[ N = \text{Number of waiver participants (or their representatives)} \]

\[ D = \text{Number of waiver participants whose service plans were reviewed} \]

**Data Source** (Select one):
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### 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

\[
N = \text{Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change}
\]

\[
D = \text{Number of waiver participants whose service plans were reviewed}
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**Data Source** (Select one):

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### 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**
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        - **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)
            - Continuously and Ongoing
            - Other
  - **Sampling Approach (check each that applies):**
    - **Stratified**
      - Describe Group:
        - Proportionate by MCO
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**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**

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- KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency (Annually)

- Continuously and Ongoing

### 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**

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

Continuous 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

\[ \text{N} = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver service providers} \]

\[ \text{D} = \text{Number of waiver participants whose files are reviewed for the documentation} \]

**Data Source** (Select one):

- **Other**
  - If ‘Other’ is selected, specify:

**Record reviews**

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Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care

\[ N = \text{Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care} \]
\[ D = \text{Number of waiver participants whose files are reviewed for the documentation} \]

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

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### Frequency of data aggregation and analysis (check each that applies):
- 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

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Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative

\[ N = \text{Number of waiver participants whose record contains documentation indicating a choice of community-based services} \]
\[ D = \text{Number of waiver participants whose files are reviewed for the documentation} \]

Data Source (Select one):
Other
If 'Other' is selected, specify:
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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)
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) All participants of IDD waiver services have the opportunity to choose the MCO that will support them in overall service access and care management. The opportunity for participant direction (self-direction) is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100).
This opportunity includes specific responsibilities required of the participant, including:
• Recruitment and selection of providers;
• Assignment of service provider hours within the limits of the authorized services;
• Complete an agreement with an enrolled Financial Management Services (FMS) provider;
• Referral of providers to the participant’s chosen FMS provider;
• Provider orientation and training;
• Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
• Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
• Other monitoring of services; and
• Dismissal of the worker, if necessary.

b) Participants are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant’s Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant’s Person-Centered Service Plan. The MCO supports the participant who selects self-direction of services by monitoring services to ensure that they are provided by Personal Care Attendants and Enhanced Care Services attendants in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider. FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:
• Verification and processing of time worked and the provision of quality assurance;
• Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers’ compensation insurance requirements; making tax payments to appropriate tax authorities;
• Performance of fiscal accounting and expenditure reporting to the participant or participant’s representative and the state, as required.
• Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant’s representative in managing and directing services;
2. Assistance to the participant or participant’s representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.
d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. Select one:

○ Participant: Employer Authority. As specified in Appendix E-2, Item a, the participant (or the participant’s representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ Participant: Budget Authority. As specified in Appendix E-2, Item b, the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

○ Both Authorities. The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

X Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

○ Waiver is designed to support only individuals who want to direct their services.

○ The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

○ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria
Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction is offered for the following services:

- ECS
- FMS
- Overnight Respite
- PCS

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

a) Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about 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 benefits of self-direction;
- 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. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

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

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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Respite Care</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Financial Management Services (FMS)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Personal Care Service</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. **Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*
  
  Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

  The waiver service entitled:

  | Financial Management Services |

- FMS are provided as an administrative activity.

Provide the following information

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

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

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant’s participant-directed budget
Track and report participant funds, disbursements and the balance of participant funds
Process and pay invoices for goods and services approved in the service plan
Provide participant with periodic reports of expenditures and the status of the participant-directed budget
Other services and supports

Specify:

Additional functions/activities:

× Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
× Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
a) The state verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment).

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) 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):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Alert Rental</td>
<td>×</td>
</tr>
<tr>
<td>Overnight Respite Care</td>
<td>×</td>
</tr>
<tr>
<td>Financial Management Services (FMS)</td>
<td>×</td>
</tr>
<tr>
<td>Residential Supports</td>
<td>×</td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Care</td>
<td></td>
</tr>
<tr>
<td>Personal Care Service</td>
<td></td>
</tr>
<tr>
<td>Assistive Services</td>
<td></td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td></td>
</tr>
<tr>
<td>Wellness Monitoring</td>
<td></td>
</tr>
<tr>
<td>Day Supports</td>
<td></td>
</tr>
</tbody>
</table>

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)

I. 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 participant's chosen MCO may discontinue self-direction and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:

1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if the health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS, and all training methods for the participant have been exhausted;
3. if the direct support worker has not adequately performed the services as outlined in the Person-Centered Service Plan (Service Plan);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or service provider has abused or misused self-direction including:
   • the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the needs assessment and/or POC;
   • the participant/representative has directed the service providers to provide, and the service providers has in fact provided paid comprehensive support or Enhanced Care Services beyond the scope of the service definition;
   • the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the Service Plan;
   • the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the service providers for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:

1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participant's attending physician or RN no longer authorizes the participant to self-direct his/her care; or
3. the participant/representative has committed a fraudulent act.

A timely Notice of Action (NOA) shall be sent to the participant prior to the effective date for termination of the participant's participation in the Self-Directed Care Option. The MCO coordinates to ensure there is not a lapse in service delivery.

The MCO works with the participant to maintain continuous attendant coverage as outlined and authorized on the participant's Service Plan. The MCO, through their care management and monitoring activities, works with the participant's choice of a non-self-directed agency to assure participant health and welfare during the transition period and beyond by communicating with both the participant and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the participant as to satisfaction with services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

**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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Employer Authority Only</th>
<th>Budget Authority Only or Budget Authority in Combination with Employer Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>2871</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>2871</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>2871</td>
<td></td>
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<td>Year 4</td>
<td>2871</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>2871</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- **Recruit staff**
- **Refer staff to agency for hiring (co-employer)**
- **Select staff from worker registry**
- **Hire staff common law employer**
- **Verify staff qualifications**
- **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

- **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

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

- **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- **Determine staff wages and benefits subject to state limits**
- **Schedule staff**
Orient and instruct staff in duties
Supervise staff
Evaluate staff performance
Verify time worked by staff and approve time sheets
Discharge staff (common law employer)
Discharge staff from providing services (co-employer)

Other
Specify:

Appendix E: Participant Direction of Services

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

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

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

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

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the state's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
-Authorize payment for waiver goods and services
-Review and approve provider invoices for services rendered

Other
Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.
ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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

b. Participant - Budget Authority

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

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

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

b. Participant - Budget Authority

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

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

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

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

b. Participant - Budget Authority

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

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

Appendix F-1: Opportunity to Request a Fair Hearing

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

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.
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 initial assessments that result in a "not eligible" determination. In addition, any reassessment that results in a change from eligible to not eligible is subject to appeal.

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.

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 you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.

An Appeal is a request for a review of any of the above actions.

Members will receive a Notice of Action in the mail if an adverse action has occurred.

To file an Appeal:
- Members or (a friend, an attorney, or anyone else on the member's behalf can file an appeal).
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 60 days calendar days after the participant has received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant’s appeal will be resolve in 45 calendar days.

If the participant is on the IDD waiver, previously authorized IDD waiver services must continue during the appeal period timeframe 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 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. The participant's MCO will inform the participant of their right to
benefit continuation during the appeal process. 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.

MCOs retain all Notices of Action in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one:

- No. This Appendix does not apply
- Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.
CDDO Dispute Process:

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. For applicable disputes, if a participant chooses to lodge a local complaint, he or she must follow the local dispute resolution process. If the participant chooses to lodge a dispute through the local dispute resolution process, this does not prevent the participant from requesting a Fair Hearing at any time.

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 plan. 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.

MCO Grievance Process:

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.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. Select one:

- No. This Appendix does not apply
Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver.

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. Participants have the right to submit grievances or appeals to their assigned managed care organization. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), requires the managed care organizations to operate a member grievance and appeal system consistent with federal regulations and Attachment D of the State’s contract with CMS. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1. KanCare members are informed that filing an appeal with the MCO is a prerequisite for a Fair Hearing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are part of the State’s fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State’s fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. 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 prerequisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager, or by the Ombudsman’s office.

Complaints are received in the DXC Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately. Grievance Unit must make contact related to a grievance within 3 business days. If the situation is urgent, the grievance staff makes contact immediately. The grievance is required to be resolved within 30 calendar days.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- Yes. The state operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
- No. This Appendix does not apply (do not complete Items b through e)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Definitions of Kansas Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 39, Article 14 for adults, 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:
  o (1) Failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child;
  o (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
  o (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 exploitive 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:
  o (1) Be photographed, filmed or depicted in pornographic material; or
  o (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. KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days,
of receiving the information. Outside of working hours, the reports shall be submitted to the DCF on the first working day that the Kansas department for children and families is in operation after receipt of such information. All other adverse incidents as defined by KDADS in this section and as defined in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 must be reported directly into the AIR system no later than 24 hours of becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110.

- The method of reporting:

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

Kansas Department for Children and Families reportable incidents and all KDADS defined adverse incidents must be reported directly into AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP. These include, in addition to suspected incidents of Abuse, Neglect, Exploitation or Fiduciary Abuse; Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Restraint, Seclusion, E/R visit, Hospitalization, Misuse of Medications, Natural Disaster, Serious Injury, Suicide, Suicide Attempt. See KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 for definitions of KDADS reportable adverse incidents. Also, the reporter can select as many adverse incidents as may apply per that particular situation. Anyone who suspects a child or adult is experiencing any of the above types of DCF reportable events or KDADS adverse incidents may also report it through the DCF hotline.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and website and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development.

Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant’s Person-Centered Service Plan. The information provided by the MCOs is consistent with the state’s Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

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. K.A.R. 30-63-28(c) requires providers to “regularly conduct training and take other steps to ensure that any agent, person, parent, guardian, and any other individual from each person's support network is advised about how to contact the appropriate state agency charged with providing adult protective services whenever abuse, neglect, or exploitation is suspected or witnessed.”

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.
• The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.

The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of the reporter becoming aware of the adverse incident by direct entry into the KDADS web-based AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP.

• The entity that is responsible for evaluating reports and how reports are evaluated:

All reports of Abuse, Neglect, Exploitation and Fiduciary Abuse are reported to and investigated by DCF. Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with, K.S.A. 38-2223 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS, which is entered into AIRS and reviewed by KDADS staff.

KDADS is the entity responsible for evaluating all adverse incident reports in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS HCBS Adverse Incident Monitoring SOP. All events reported to AIRS are reviewed by KDADS staff to determine whether or not they meet the SOP definition of an adverse incident. Those that do not are screened out from further investigation by KDADS. Those that meet the definition are investigated by KDADS and contracted MCOs. Any event reported through AIRS that involves the possible abuse, neglect, exploitation or fiduciary abuse of children that was not reported first to DCF is immediately reported to DCF by KDADS for further investigation.

In accordance with the KDADS HCBS Adverse Incidents Monitoring Standard Operating Procedure (SOP), KDADS Program Integrity and Compliance Specialists (PICS) or their designated back-up(s) are responsible for checking AIRS for any newly reported adverse incident. AIRS will automatically distribute adverse incident reports for review based on the issue, KDADS provider/program type (e.g., Behavioral Health, Older Americans Act, Senior Care Act, HCBS Waiver), and county location of the incident. If data was entered incorrectly, the KDADS PICS must correct any errors, and re-route the review to the appropriate KDADS party. This process will occur within one business day of receipt of an adverse incident report.

If AIRS does not auto assign the adverse incident, the KDADS PICS will review the adverse incident report and assign it appropriately within AIR. If the member requires protective services intervention or review, the PICS will immediately notify and forward the adverse incident report to (DCF) for further investigation.

If an Adverse Incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in each of the HCBS waivers. DCF must notify KDADS outlining DCF’s determination for the incident within five business days of the date of DCF determination, in accordance with the DCF Policy and Procedure Manual (Chapter 10320) and as defined in KSA 39-1433/38-2226.

For all submitted AIR reports, PICS first review AIRS adverse incident report information to determine if there is any indication of criminal activity and report any instances to law enforcement. If it is determined that there is suspected for Abuse, Neglect, Exploitation or Fiduciary Abuse, the KDADS PICS report immediately to DCF. Any areas of vulnerability would be identified for Additional training and assurance of education. PICS determine if the adverse incident report is screened in, screened out, or requires additional follow-up. Even for those incidents referred to DCF,
PICS document the incident and notify the participant’s MCO of the incident.

Within one business day of receiving an AIR report, KDADS PICS will determine the level of severity for each screened in adverse incident reported in AIRS, and will assign a level of severity. Within one business day of a determination of the severity level PICS will notify the participant’s MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up. KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member’s Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP.

- The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. Per PPS policy number 1521, reports assigned for Abuse/Neglect concerns shall be assigned with either a same day or 72-hour response time. Reports assigned as Non-Abuse/Neglect Family in Need of Assessment (NAN FINA) are assigned a response time per PPS policy number 1670. PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. KDADS assigns the report to the participant’s managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

- The entity that is responsible for conducting investigations and how investigations are conducted:

DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

Review and Follow-up for Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children.

1. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF, if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services.
2. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS.
3. The report will not be assigned for further assessment or may be screened out after acceptance if the following apply:
   a. The report does not meet the criteria for further assessment per DCF PPS Policy and Procedure Manual;
   b. The event has previously been investigated;
   c. DCF does not have the statutory authority to investigate;
   d. Unable to locate family.
4. Not all reportable events require remediation; DCF shall determine which reportable events will result in remediation.
The process and timeframes for informing the participant (or the participant’s family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results includes:

Notice of Department Finding per DCF PPS Policy Number 2540:
The Notice of Department Finding for reports is PPS 2012. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.

All case decisions/findings shall be staffed with the CPS Supervisor/designee and a finding shall be made within thirty (30) working days of receiving the report. DCF sends the Notice of Department Finding to relevant persons who have a need to know of the outcome of an investigation of child abuse/neglect on the same day, or the next business day, of the case finding decision.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.

KDADS first reviews the adverse incident report information to determine if there is any indication of criminal activity or ANE that has not been reported to appropriate agencies. If the incident has not already been reported to DCF, KDADS reports it to DCF. KDADS next determines if the incident is screened in, screened-out, or requires follow-up. For all screened in adverse incidents, KDADS staff assign a severity level. MCOs take steps for follow-up with providers/members, and resolve the incident or implement remediation steps. KDADS tracks and approves MCO investigation and resolution steps. KDADS staff review MCO follow-up and resolution details. KDADS also determines if the incident should require a corrective action plan (CAP) outlining the deficiencies and necessary steps to resolve. KDADS monitors MCO CAP remediation efforts and required completion dates to ensure timely resolution.

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.

If an adverse incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in this waiver. DCF must send information to KDADS outlining DCF’s determination for the incident. KDADS incorporates the information within the AIR system, either as a new report or added to an already existing AIR report.

• 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 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:

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 described in the required documentation section below. From on-set of behavior to discontinuation of the restraint, the staff reflect on and document the Support Plan strategies they would implement again, or they would use differently. Staff shall notify the care coordinator and the parent/legal guardian, as identified in the Support Plan.

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 Support Plan strategies they would implement again, or they would use differently;
8. Notify care coordinator, as identified in the Support Plan;

• 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 Support Plan 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 restraint and ensuring that all applicable state requirements are followed:
All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or 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.
<table>
<thead>
<tr>
<th>•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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>•For each type of restrictive intervention that is permitted, the state’s safeguards address:</td>
</tr>
<tr>
<td>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 the following methods are used to avoid the use of restrictive interventions.</td>
</tr>
<tr>
<td>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.”</td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>1. What is the person’s history of decision-making?</td>
</tr>
<tr>
<td>2. What are the possible long and short-term consequences associated with poor decision making? (What is the worst that could happen?)</td>
</tr>
<tr>
<td>3. What are the possible long and short-term consequences of increased direction and control by staff or system?</td>
</tr>
<tr>
<td>4. Existence of safeguards to protect the person’s rights.</td>
</tr>
<tr>
<td>5. Should more control and direction be provided? If yes, describe the proposed support which causes the least intrusion while adequately protecting the consumer.</td>
</tr>
<tr>
<td>Review of this information is monitored by KDADS field staff.</td>
</tr>
<tr>
<td>A Behavior Support Plan is monitored in accordance with the following standards and is included in the individual’s Person-Centered Service Plan.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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</td>
</tr>
</tbody>
</table>
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:

The proactive and remedial actions include: (1) Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and documentation of those safeguards, in consultation with the person, the person’s guardian, and the person’s support network, (2) Management, which shall include initial and ongoing assessment and responsive modifications that may be needed, and (3) Review by a behavior management committee established by the provider.

For any restriction of an individual’s access to person, places or things 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.

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.
When restrictive intervention 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 restrictive intervention as described in the required documentation section below. From on-set of behavior to discontinuation of the restrictive intervention, the staff reflect on and document the Support Plan strategies they would implement again, or they would use differently. Staff shall notify the care coordinator and the parent/legal guardian, as identified in the Support Plan.

Review of this information is monitored by KDADS field staff.

*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 one 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 restrictive interventions 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).
For each type of seclusion that is permitted, the state’s safeguards address these seclusions using the same approach as it does for restrictive interventions. Restrictive intervention language is regulatory language and applies to seclusion as follows:

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 seclusion the following methods are used to avoid the use of seclusion.

For any seclusion 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.

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 seclusion 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 seclusion:

Oversight to detect unauthorized use of seclusion 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 seclusion.

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 seclusion.

*Protocols for authorizing the use of seclusion, including treatment planning requirements and review/reauthorization procedures:

The proactive and remedial actions include:

1. Safeguards, which shall include initial and ongoing assessment and responsive modifications that may be needed to ensure and documentation of those safeguards, in consultation with the person, the person’s guardian, and the person’s support network, (2) Management, which shall include initial and ongoing
assessment and responsive modifications that may be needed, and (3) Review by a behavior management committee established by the provider.

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 seclusion 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 seclusion 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 seclusion 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.

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 seclusions 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.

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 seclusion as described in the required documentation section below. From on-set of behavior to discontinuation of seclusion, the staff reflect on and document the Support Plan strategies they would implement again, or they would use differently. Staff shall notify the care coordinator and the parent/legal guardian, as identified in the Support Plan.

Review of this information is monitored by KDADS field staff.

*Required documentation when seclusions 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.

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 seclusion 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 seclusion 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 seclusions 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 seclusions:

Required Seclusion 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 seclusion 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 seclusion, 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 seclusion in their plan as an approvable intervention.

**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:

A finding of screened out is given to reports that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

The DCF determination informs KDADS’ direction to MCOs on appropriate investigation and remediation steps. All screened out, unsubstantiated, and substantiated determinations by DCF meet the definition of an adverse incident, are “screened in” by KDADS and entered into the AIR system for remediation and follow-up.

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 regimens. 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 medication to manage behavior or to treat diagnosed mental illness. 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, and at least annually, on-site in-person reviews with persons served by the agency. KDADS Regional Field Staff monitor and assure compliance with:
  K.A.R. 30-63-22. 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.

Safeguards:
K.A.R. 30-63-23 requires that safeguards, including 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 (A) 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; (B) positive behavior programming, environmental modifications and accommodations, and effective services from the provider are present in the person’s life; (C) 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 (D) 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 one 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.

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 (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 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 expired 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. 30-63-22. 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.

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
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.

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.


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 instances of 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

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Performance Measure:
Number and percent of unexpected deaths for which the appropriate follow-up measures were taken.

N = Number of unexpected deaths for which the appropriate follow-up measures were taken
D = Number of unexpected deaths

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

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### 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**

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**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**

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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

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Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures 

\[
\text{N = Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures} \]

\[
\text{D = Number of reported critical incidents.}
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Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Management System

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Managed Care Organizations (MCOs) participate in analysis of this measure's results as determined by the State.
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

\[ N = \text{Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver} \]
\[ D = \text{Number of restraint applications, seclusion or other restrictive interventions.} \]

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

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**Data Aggregation and Analysis:**

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**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:

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**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**

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### Sample Confidence Interval

- 95%

#### Other
- Specify:
  - KanCare Managed Care Organizations (MCOs)

#### Annually
- × Stratified
- Describe Group:
  - Proportionate by MCO

#### Continuously and Ongoing
- × Other
- Specify:

### Data Aggregation and Analysis:

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| × Other
- Specify: KanCare MCOs participate in analysis of these measures results as determined by the State | × 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

\[ N = \text{Number of waiver participants who have a disaster red flag designation with a related disaster backup plan} \]
\[ D = \text{Number of waiver participants with a red flag designation} \]

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

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<td>Other Specify:</td>
<td>Continuously and Ongoing</td>
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Data Aggregation and Analysis:
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)

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<th>Responsible Party (check each that applies):</th>
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### c. Timelines

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

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the state’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term care services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-I: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.
The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

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

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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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population
in the last 12 months (Select one):

- No
- Yes (Complete item H.2b)

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.

b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

The state conducts a 5% (95/5) sample for case files reviews of MCOs and Assessors, the sample results in a 95% confidence level and a +/- 5% confidence interval.

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 1915(b) 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.

Eligibility is received from KEES, the state’s system for determining eligibility. Capitation payments are made based off a rate cell that is set by Population Codes, Level of Care, Age or any combination of those. Members will qualify for HCBS rate cells based off of their Level of Care.

Waiver services can be furnished on an FFS basis. The claims are processed through the claims engine based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. All FFS claims are monitored for accuracy by the DXC SURS team. If determined a provider was paid for services not rendered under FFS, the claim would be adjusted to recoup the funds paid.

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.

07/05/2023
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 immediately or within 24 hours of becoming aware of the allegation of abuse, fraud or waste 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.

KDHE is responsible for Provider enrollment with the Medicaid fiscal agent. KDADS performs various reviews and audits of the MCOs regarding HCBS including but not limited to report reviews, quarterly case file reviews, annual reviews, provider qualification reviews.

The claims engine is referencing the Medicaid Management Information System (MMIS) claims engine. The MMIS is a part of the Medicaid fiscal agent contract.

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

\[
N = \text{Number of provider claims that are coded and paid in accordance with the state’s approved reimbursement methodology}
\]
\[
D = \text{Total number of provider claims paid}
\]

**Data Source (Select one):**
Other
If 'Other' is selected, specify:
DSS/DAI Encounter Data

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| 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):
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× State Medicaid Agency | Weekly
× Operating Agency | Monthly
Sub-State Entity | Quarterly
× Other
Specify: KanCare Managed Care Organizations (MCO) participate in the analysis of this measure's results as determined by the State operating agency | × Annually
Continuous 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):
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× Operating Agency | Monthly | Less than 100% Review
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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

\[ N = \text{number of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS} \]
\[ D = \text{Total number of capitation (payment) rates} \]

**Data Source (Select one):**

- Other

If ‘Other’ is selected, specify:

**Rate Setting Documentation**

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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)

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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.

Fee for Service
Certain populations have the ability to opt out of the Managed Care delivery system and receive services via fee-for-service (FFS). The FFS provider would be paid per the state’s fee schedule. The State is responsible for setting FFS rates. In managed care, the FFS rates are the minimum required to be paid by MCOs, but actual rates are negotiated by the provider through the contracting process.

Day Supports and Residential services FFS rates are set with tiered rates. All other IDD services are reimbursed by a single rate.
The State Operating Agency, in coordination with the State Medicaid Agency, is responsible for FFS rate determination. The State ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt out from Managed Care. In the event, there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available. FFS rates can be found via State Bulletins via the State’s KMAP website.

The State ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt out from Managed Care. In the event, there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available. FFS rates can be found via State Bulletins via the State’s KMAP website. Waiver participants can obtain FFS rates by contacting the State Operating Agency directly.

The State understands that this section must be amended with a description of a public comment process compliant with the guidance as laid out in 42 CFR 447.205 if anyone enrolled in the waiver were to opt out of managed care.

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.

Claims are received via electronic or paper media. Electronic claims are separated out between MCO and FFS based on the Beneficiary ID and the first date of service on the claim compared with the eligibility file. The claims, where assignment to an MCO is found for that date of service, are sent to the MCO for processing. Claims without an MCO assignment are processed FFS.

Paper claims are sent back to the provider if it can be determined the beneficiary is assigned to an MCO. Otherwise, the claims are processed through the MMIS claims engine and deny if the beneficiary is assigned to an MCO or process through the MMIS claims engine if not assigned.

The claims are processed through the MMIS claims engine based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

In Kansas, Community Developmental Disability Organizations (CDDOs) are responsible for acting as the single point of entry for IDD services and are also responsible for functional assessments for the IDD Waiver. CDDOs are reimbursed for these administrative services and functional assessments through contractual agreement between the State and each CDDO. These functions are reimbursed to CDDOs through the KDADS Management information System (MIS) and the State’s Accounting System. It should also be noted that while the CDDO conducts the functional assessment, the eligibility determination is made by the State.

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.)

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**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. The claims are processed through the claims engine based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Beneficiary’s benefit plan for a waiver participant means Medicaid eligible with the LOC of I/DD waiver. The beneficiary’s benefit plan refers to the waiver participant’s Person-centered Service Plan.

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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.

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**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:
In the event an FFS participant chose to Self-Direct their services; those services would be provided by an FMS provider that is enrolled with the Medicaid Program. FFS providers have the option to be paid via a check or through EFT. Payment is made based on the provider’s preference.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state’s contract with managed care entities.

All of the waiver services in this program are included in the state’s contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The state does not make supplemental or enhanced payments for waiver services.
- Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

In some instances there are county level government agencies, i.e., CDDOs/providers that provide services. These county level government agencies are CDDO/providers. These services include, all waiver services including, Residential, Day, PCS, ECS, Assistive Services, Overnight Respite, FMS, Wellness Monitoring and Medical Alert Rental. The state contracts with 27 CDDOs with five being tied to their county government. The five CDDOs that are a part of county level government serve as both a CDDO and a provider.
Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state. Anyone received their services through FFS, the provider would retain 100% of the amount claimed.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).
Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.
- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may...
voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

× Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the 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. In the event an individual opts out of managed care, fee for services payments will be made via the state’s MMIS via the process indicated above.

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:

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**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
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>41266.65</td>
<td>9119.00</td>
<td>50385.65</td>
<td>82001.00</td>
<td>7428.00</td>
<td>89429.00</td>
<td>39043.35</td>
</tr>
<tr>
<td>2</td>
<td>41266.65</td>
<td>9119.00</td>
<td>50385.65</td>
<td>82001.00</td>
<td>7428.00</td>
<td>89429.00</td>
<td>39043.35</td>
</tr>
<tr>
<td>3</td>
<td>41266.65</td>
<td>9119.00</td>
<td>50385.65</td>
<td>82001.00</td>
<td>7428.00</td>
<td>89429.00</td>
<td>39043.35</td>
</tr>
<tr>
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<td>41266.65</td>
<td>9119.00</td>
<td>50385.65</td>
<td>82001.00</td>
<td>7428.00</td>
<td>89429.00</td>
<td>39043.35</td>
</tr>
<tr>
<td>5</td>
<td>41266.65</td>
<td>9119.00</td>
<td>50385.65</td>
<td>82001.00</td>
<td>7428.00</td>
<td>89429.00</td>
<td>39043.35</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>9491</td>
<td>ICF/IID</td>
</tr>
<tr>
<td>Year 2</td>
<td>9491</td>
<td>9491</td>
</tr>
<tr>
<td>Year 3</td>
<td>9491</td>
<td>9491</td>
</tr>
<tr>
<td>Year 4</td>
<td>9491</td>
<td>9491</td>
</tr>
<tr>
<td>Year 5</td>
<td>9491</td>
<td>9491</td>
</tr>
</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) estimate is derived from the unduplicated participants listed in the current waiver and the days of waiver enrollment from the most recent CMS-372 report for state fiscal year 2017. The ALOS was projected by dividing 3,332,693 (the days of waiver enrollment) by 9,491 (unduplicated participants). The projected average length of stay for this renewal is 351.
Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is estimated by utilizing encounter data from the Kansas Medicaid Management Information System and reflects MCO payments to the providers, using a three-year average (SFY2015 through SFY2017). This is an estimate of MCO encounters and is not reflective of the State’s capitation payments made to the MCO. It should be noted these estimates would account for participants choosing to opt out of managed care.

The state reports Factor D on the 372 report based on the managed care instructions received from CMS on 1/26/2015. The derivation of Factor D reported in the waiver renewal is based upon the Appendix J reporting methodology that was approved by CMS on 5/24/2016.

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 (SFY2015 through SFY2017) of waiver capitation costs less a three-year average (SFY2015 through SFY2017) of MCO encounter payment costs. The waiver capitation costs and MCO encounter payment costs are derived from the Kansas Medicaid Management Information System.

The state reports Factor D’ on the 372 report based on the managed care instructions received from CMS on 1/26/2015. The derivation of Factor D’ reported in the waiver renewal is based upon the Appendix J reporting methodology that was approved by CMS on 5/24/2016.

Factor D’ estimates do not include the cost of prescribed drugs that are furnished to Medicare/Medicaid dual eligible under the provisions of Medicare Part D.

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 encounter data from the Kansas Medicaid Management Information System and reflects MCO payments to the institutional providers, using a three-year average (SFY2015 through SFY2017). This is an estimate of MCO encounters and is not reflective of the State’s capitation payments made to the MCO.

The state reports Factor G on the 372 report based on the managed care instructions received from CMS on 1/26/2015. The derivation of Factor G reported in the waiver renewal is based upon the Appendix J reporting methodology that was approved by CMS on 5/24/2016.

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 (SFY2015 through SFY2017) of the institutional alternative capitation costs minus a three-year average (SFY2015 through SFY2017) of MCO institutional alternative encounter payment costs. The institutional capitation costs and MCO encounter payment costs are derived from the Kansas Medicaid Management Information System.

The state reports Factor $G'$ on the 372 report based on the managed care instructions received from CMS on 1/26/2015. The derivation of Factor $G'$ reported in the waiver renewal is based upon the Appendix J reporting methodology that was approved by CMS on 5/24/2016.

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.

<table>
<thead>
<tr>
<th>Waiver Services</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overnight Respite Care</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Service</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Supports</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
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</tr>
<tr>
<td>Financial Management Services (FMS)</td>
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<tr>
<td>Enhanced Care Service</td>
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<tr>
<td>Medical Alert Rental</td>
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<tr>
<td>Specialized Medical Care</td>
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<td>Wellness Monitoring</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>112179998.71</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:** 391661794.88

Total: Services included in capitation: 391661794.88

Total: Services not included in capitation: 9491

Total Estimated Unduplicated Participants: 41266.65

Factor D (Divide total by number of participants): 41266.65

Services included in capitation: 41266.65

Services not included in capitation: 9491

Average Length of Stay on the Waiver: 351
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Supports</td>
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<td>15 minutes</td>
<td>6725</td>
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<td>112179998.71</td>
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<tr>
<td>Overnight Respite Care</td>
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<td>1 day</td>
<td>75</td>
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<td>227679273.00</td>
<td>227679273.00</td>
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**GRAND TOTAL:** 391661794.88

Total: Services included in capitation: 391661794.88

Total: Services not included in capitation: 41266.65

Total Estimated Unduplicated Participants: 9491

Factor D (Divide total by number of participants): 41266.65

Services included in capitation: 41266.65

Services not included in capitation: 41266.65

Average Length of Stay on the Waiver: 351
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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**GRAND TOTAL:**

- Total: Services included in capitation: 391661794.88
- Total: Services not included in capitation: 9491
- Total Estimated Unduplicated Participants: 41266.65
- Factor D (Divide total by number of participants): 9491
- Services included in capitation: 41266.65
- Services not included in capitation: 9491

**Average Length of Stay on the Waiver:** 351
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<th>Avg. Cost/ Unit</th>
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Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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Total: Services included in capitation: 391663794.88
Total: Services not included in capitation: 9491
Total Estimated Unduplicated Participants: 40266.65
Factor D (Divide total by number of participants): 9491
Services included in capitation: 391663794.88
Services not included in capitation: 9491

Average Length of Stay on the Waiver: 351
## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 4

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<tr>
<td><strong>GRAND TOTAL:</strong></td>
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<td>Unit</td>
<td># Users</td>
<td>Avg. Units Per User</td>
<td>Avg. Cost/Unit</td>
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<td>Total Cost</td>
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<tr>
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<td>15 minutes</td>
<td>54</td>
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<td>3.25</td>
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<td></td>
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<td>1157891.36</td>
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<td>1 unit of service</td>
<td>113</td>
<td>192.14</td>
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<td>72</td>
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</table>

**GRAND TOTAL:**

- Services included in capitation: $391661794.88
- Services not included in capitation: $391661794.88
- Total Estimated Unduplicated Participants: 9491
- Factor D (Divide total by number of participants): $41266.65
- Services included in capitation: $41266.65
- Services not included in capitation: $41266.65
- Average Length of Stay on the Waiver: 351

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**
<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<td></td>
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<td>Financial Management Services (FMS)</td>
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<tr>
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<td>381370.78</td>
</tr>
<tr>
<td>Assistive Services</td>
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<td>1 purchase</td>
<td>62</td>
<td>7.72</td>
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<td>1157891.36</td>
</tr>
<tr>
<td>Enhanced Care Service</td>
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<td>1 unit of service</td>
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<td>192.14</td>
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<td>10742.10</td>
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<td>1 month</td>
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<td></td>
<td></td>
<td>3810454.49</td>
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<td>×</td>
<td></td>
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<td>×</td>
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<td>3235743.18</td>
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</tr>
</tbody>
</table>

GRAND TOTAL: 391661794.88

Factor D (Divide total by number of participants): 41266.65

Average Length of Stay on the Waiver: 351
| Wellness Monitoring Total: | | | | | Total Cost |
|--------------------------|----------------|----------------|----------------|----------------|
| Wellness Monitoring      | 981            | 4.76           | 30.36          | 141767.84      |

**GRAND TOTAL:**

| Total: Services included in capitation: | 391661794.88 |
| Total: Services not included in capitation: | |
| Total Estimated Unduplicated Participants: | 9491 |
| Factor D (Divide total by number of participants): | 41266.65 |
| Services included in capitation: | 41266.65 |
| Services not included in capitation: | |

Average Length of Stay on the Waiver: 351
Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
  Kansas HCBS Brain Injury Waiver

C. Waiver Number: KS.4164
   Original Base Waiver Number: KS.4164.

D. Amendment Number:

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

01/01/24

Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

To align this waiver with the submission of the State's 1915 (b) application.

3. Nature of the Amendment

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

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Application</td>
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<tr>
<td>Appendix A</td>
<td></td>
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<tr>
<td>Administration and Operation</td>
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<tr>
<td>Appendix B</td>
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</table>
### 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. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

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

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<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
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<tbody>
<tr>
<td>Participant Access and Eligibility</td>
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<tr>
<td>Appendix C Participant Services</td>
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<tr>
<td>Appendix D Participant Centered Service Planning and Delivery</td>
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<tr>
<td>Appendix E Participant Direction of Services</td>
<td></td>
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<tr>
<td>Appendix F Participant Rights</td>
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<tr>
<td>Appendix G Participant Safeguards</td>
<td></td>
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<tr>
<td>Appendix H</td>
<td></td>
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<tr>
<td>Appendix I Financial Accountability</td>
<td></td>
</tr>
<tr>
<td>Appendix J Cost-Neutrality Demonstration</td>
<td></td>
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</tbody>
</table>
B. Program Title (optional - this title will be used to locate this waiver in the finder):

Kansas HCBS Brain Injury Waiver

C. Type of Request: amendment

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

☐ 3 years ☐ 5 years

Original Base Waiver Number: KS.4164
Draft ID: KS.012.06.10

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19
Approved Effective Date of Waiver being Amended: 07/01/19

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☒ Hospital
Select applicable level of care

☐ Hospital as defined in 42 CFR §440.10
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Traumatic Brain Injury Rehabilitation Facility and hospital

☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 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:

This amendment is being submitted simultaneously with the 1915(b) application.

Specify the §1915(b) authorities under which this program operates (check each that applies):

○ §1915(b)(1) (mandated enrollment to managed care)

○ §1915(b)(2) (central broker)

○ §1915(b)(3) (employ cost savings to furnish additional services)

○ §1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

○ This waiver provides services for individuals who are eligible for both Medicare and Medicaid.
2. Brief Waiver Description

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

The purpose of the Brain Injury (BI) waiver is to provide eligible Kansans the option to receive services in their home and community in a cost-efficient manner, as well as deinstitutionalizing individuals already being served in these settings. The program diverts individuals with a BI from seeking services from more expensive, non-inclusive, institutional settings. BI waiver services are provided in the participant's home or community setting.

1. Meet the criteria for placement in a Traumatic Brain Injury Rehabilitation Facility (TBIRF) or hospital;
2. Be 0 to 64 years of age;
3. Be a resident of the state of Kansas;
4. Be financially eligible for Medicaid;
5. Have potential for progress in habilitation/rehabilitation or a need related to the BI for therapies in order to maintain independent living skills; and
6. Have a documented medical diagnosis of a Traumatic Brain Injury or Acquired Brain Injury (TBI or ABI). Brain Injuries due to a chromosomal or congenital diagnosis do not qualify for the BI waiver.
7. For participants between the ages of 0-64, must meet level of care eligibility based on the State approved Functional Eligibility Instruments.

Participants must meet LOC based on the appropriate tool for their age group as described in Appendix B.

To qualify under a BI diagnosis, for ages four (4) to sixteen (16), the participant must meet the level of care required for hospital placement. To qualify under a BI diagnosis for ages 0 to 3, the participant must have documentation from a physician indicating the BI diagnosis. Brain Injuries due to a chromosomal or congenital diagnosis do not qualify for the BI waiver.

The BI waiver is a habilitative/rehabilitation program with an emphasis on the development of new independent living skills and/or re-learning of lost independent living skills. Individuals who receive services through this waiver may continue to do so until it is determined that they are no longer making habilitative/rehabilitative progress. Participants will go through a formal review process to determine if the habilitative/rehabilitative needs are being met by the program and the participant is continuing to make progress. Progress is evaluated every six months or more frequently as deemed necessary by the MCO or as requested by the participant. S.M.A.R.T. goals, developed by the provider, individual, and MCO, are used to track habilitative and rehabilitative progress in independent living skills. There are opportunities for waiver participants to self-direct certain services within the BI waiver. The state also offers agency-directed options for all BI waiver services.

BI program services will be provided as part of a comprehensive package of services provided by the KanCare health plans Managed Care Organizations (MCO), and will be paid as part of a capitated rate. The contracted functional eligibility assessor screens for reasonable indicators of program eligibility and conducts a functional eligibility assessment to determine if the participant meets program level of care threshold. The BI Program Manager is responsible for ensuring the documentation supports the injury is in accordance with program requirements. The MCOs are responsible for conducting the needs assessment in order to determine the participant’s level of service needs and developing a Person-Centered Service Plan than includes both behavioral, physical and BI services. The following services are available through the BI waiver:

- Assistive Services (assistive technology and home modifications)
- Behavior Therapy
- Cognitive Rehabilitation
- Enhanced Care Services
- Financial Management Services
- Home-Delivered Meals Service
- Medication Reminder Services
- Occupational Therapy
- Personal Emergency Response System and Installation
- Personal Services
- Physical Therapy
- Speech/Language Therapy
- Transitional Living Skills
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 inpatients of a hospital, nursing facility or ICF/IID.

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
G. **Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

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

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

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

7. **Contact Person(s)**

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

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Graff-Hendrixson</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Bobbie</td>
</tr>
<tr>
<td>Title:</td>
<td>Senior Manager, Contracts and Fiscal Agent Operations</td>
</tr>
<tr>
<td>Agency:</td>
<td>Kansas Department of Health and Environment</td>
</tr>
<tr>
<td>Address:</td>
<td>Landon State Office Building, Suite 900 North</td>
</tr>
<tr>
<td>Address 2:</td>
<td>900 SW Jackson Street</td>
</tr>
<tr>
<td>City:</td>
<td>Topeka</td>
</tr>
<tr>
<td>State:</td>
<td>Kansas</td>
</tr>
</tbody>
</table>

07/05/2023
8. Authorizing Signature

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

Signature: ___________________________  07/05/2023
State Medicaid Director or Designee

Submission Date: __________

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

Last Name: __________
First Name: __________
Title: __________
Agency: __________
Address: __________
Address 2: __________
City: __________
State: Kansas
Zip: __________
Phone: __________ Ext: __________ TTY
Fax: __________
E-mail: __________

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

There will be no negative impact to the waiver participants.

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

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

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

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

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

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

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

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

### Appendix A: Waiver Administration and Operation

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

   - The waiver is operated by the state Medicaid agency.

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

     - The Medical Assistance Unit.

     Specify the unit name:

     *(Do not complete item A-2)*

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

     Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Kansas Department for Aging and Disability Services / Community Services and Programs Commission

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

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

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

a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
   - Information received from CMS;
   - Proposed policy changes;
   - Waiver amendments and changes;
   - Data collected through the quality review process
   - Eligibility, numbers of participants being served
   - Fiscal projections; and
   - Any other topics related to the waivers and Medicaid.

b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.

c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.

d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of the KanCare MCO contracts. KDHE collaborates with KDADS regarding HCBS program management, including those items identified in part (a) above. The overall state’s KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state’s KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA’s monitoring of delegated functions to the Operating Agency) will be guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes will be on a quarterly basis. While continuous monitoring will be conducted, including on monthly and other intervals, the aggregation,
analysis and trending processes will be built around that quarterly structure. Kansas has amended the KanCare QIS to include the concurrent HCBS waiver connections and will be seeking CMS approval of amendments of the HCBS waivers that embed the KanCare QIS structure.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (select one):

- **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  
  Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6:

  KDADS contracts with the Aging and Disability Resource Centers (ADRC) to receive HCBS referrals, provide options counseling, complete the standard intake and conduct the functional eligibility assessment for the BI waiver.

  The MCOs, or their designee, conducts a comprehensive needs assessment, develops the Person-Centered Service Plan and the Participant Interest Inventory (PII) that includes both state plan services and BI waiver services, offers provider choice, choice between self or agency direction, conducts provider credentialing, provider training, monitoring of service delivery and participates in the comprehensive state quality improvement strategy for the KanCare program.

- **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (Select One):

- **Not applicable**
- **Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.**
  Check each that applies:

  **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

  Specify the nature of these agencies and complete items A-5 and A-6:

  **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  Specify the nature of these entities and complete items A-5 and A-6:
Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Kansas Department for Aging and Disability Services/ Community Services and Programs Commission

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Contracted entities, including both contracted entities/providers and the state’s contracted MCOs, are monitored through the State’s KanCare Quality Improvement Strategy (QIS), which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. All functions delegated to contracted entities are included in the State’s comprehensive quality strategy review processes. A key component of that monitoring and review process is collaboration between KDHE and KDADS which includes HCBS waiver management staff from KDADS. In addition, the SSMA and the State Operating Agency will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will include oversight and monitoring of all HCBS programs and the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy ensures that the entities contracting with KDADS are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1915(b) waiver, Kansas statutes and regulations, and related policies. Included in the QIS will be ongoing assessment of the results of onsite monitoring and individual reviews with a sample of HCBS waiver participants.

KDHE monitors KDADS’ development of operational processes and collaborates with KDADS to ensure that appropriate administrative oversight components are specified in those processes. Through existing KDHE policy review processes and monthly KDHE Long Term Care (LTC) meeting updates/reports, KDHE ensures implementation of the operational processes to include KDHE monitoring of quality measures via quarterly and ad hoc reporting by KDADS to KDHE, as well as periodic sample review by KDHE.

In addition to the review of contracted entities, the operating agency conducts participant surveys to gather data on access to services and effectiveness of services delivery. Oversight is conducted on a quarterly basis. In instances where the operating agency is primarily responsible for conducting the quality review, the operating agency will analyze and compile the contracted entities performance results and report the findings and summaries to the Medicaid agency.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant waiver enrollment</td>
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<td>×</td>
<td></td>
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<tr>
<td>Function</td>
<td>Medicaid Agency</td>
<td>Other State Operating Agency</td>
<td>Contracted Entity</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------</td>
<td>------------------------------</td>
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</tr>
<tr>
<td>Waiver enrollment managed against approved limits</td>
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<td>Level of care evaluation</td>
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<td>Review of Participant service plans</td>
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<td>Prior authorization of waiver services</td>
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<td>Qualified provider enrollment</td>
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<td>Rules, policies, procedures and information development</td>
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<td>governing the waiver program</td>
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<tr>
<td>Quality assurance and quality improvement activities</td>
<td>X</td>
<td>X</td>
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</tr>
</tbody>
</table>

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 policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency:

\[ \text{N} = \text{Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency} \]

\[ \text{D} = \text{Number of waiver policy changes implemented by the Operating Agency} \]
**Data Source** (Select one):

Other

If 'Other' is selected, specify:

**Presentation of waiver policy changes**

<table>
<thead>
<tr>
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<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>× 100% Review</td>
</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
<td>Representative Sample</td>
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<td></td>
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<td>Confidence Interval =</td>
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<tr>
<td>Other</td>
<td>Annually</td>
<td>Stratified</td>
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<td>Describe Group:</td>
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<td>× Continuously and Ongoing</td>
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**Data Aggregation and Analysis:**

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<tr>
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Responsible Party for data aggregation and analysis *(check each that applies):*  

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</tr>
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</table>

Other  
Specify:

Performance Measure:  
Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency  

N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency  
D=Number of Quality Review reports

Data Source *(Select one):*  
Other  
If 'Other' is selected, specify:

Quality review reports

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<td>Describe Group:</td>
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<td>Frequency of data aggregation and analysis (check each that applies):</td>
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<tr>
<td><strong>Operating Agency</strong></td>
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<td></td>
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<tr>
<td><strong>Sub-State Entity</strong></td>
<td>Quarterly</td>
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<td>Annually</td>
<td></td>
</tr>
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<td>Other Specify:</td>
<td>Continuously and Ongoing</td>
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</table>

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:

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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<tr>
<td><strong>Operating Agency</strong></td>
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### Data Aggregation and Analysis:

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</tr>
<tr>
<td>× Operating Agency</td>
<td>Monthly</td>
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<td>Sub-State Entity</td>
<td>× Quarterly</td>
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<td>Annually</td>
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<td>× Continuously and Ongoing</td>
</tr>
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</tbody>
</table>
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

\[ N = \text{Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS} \]
\[ D = \text{Total number of waiver amendments and renewals} \]

Data Source (Select one):
Other
If 'Other' is selected, specify:

<table>
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<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>Weekly</td>
<td>✗ 100% Review</td>
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<tr>
<td>✗ Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>✗ Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence Interval =</td>
</tr>
<tr>
<td>Other</td>
<td>✗ Annually</td>
<td>Stratified</td>
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<tr>
<td></td>
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<td>Describe Group:</td>
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<tr>
<td></td>
<td>✗ Continuously and Ongoing</td>
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Data Aggregation and Analysis:

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<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
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<td>✗ State Medicaid Agency</td>
<td>Weekly</td>
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</tbody>
</table>
### Responsible Party for data aggregation and analysis (check each that applies):

<table>
<thead>
<tr>
<th>Operating Agency</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

Other
Specify:

| Annually |

| Continuously and Ongoing |

Other
Specify:

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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 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 was operationalized, staff of the three plans were engaged with state staff to ensure 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 program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

---

### b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
KDHE and KDADS have a standing weekly policy meeting to review all KDADS and KDHE policies prior to finalization and public posting. KDHE assigns policy numbers to all final KDADS’ policies. No policy may be assigned a policy number without being reviewed and approved by KDHE at the weekly meeting.

KDADS Quality Management Staff have a standing schedule and timeline by which reviews must be completed and a report generated. The results of the quality reviews are submitted to the KDHE and KDADS Long Term Care meeting for review. Any issues with the reports are discussed and follow up action assigned during those meetings. In addition, KDADS Quality Staff and HCBS Program Staff meet monthly to discuss findings from the quality reviews and any process changes that are needed.

The HCBS Director is responsible for ensuring attendance of HCBS Program Managers at the monthly Long Term Care meetings. Any disciplinary action needed is handled by the HCBS Director.

KDHE and KDADS have a process in place to ensure all waiver amendments are reviewed and approved prior to submission to CMS. KDHE has ultimate responsibility for submitting waiver renewals and amendment to CMS.

<table>
<thead>
<tr>
<th>ii. Remediation Data Aggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remediation-related Data Aggregation and Analysis (including trend identification)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Frequency of data aggregation and analysis</th>
</tr>
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<td>(check each that applies):</td>
<td>(check each that applies):</td>
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<td>✔ Operating Agency</td>
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<td>Annually</td>
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<tr>
<td></td>
<td>✔ Continuously and Ongoing</td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
</tr>
</tbody>
</table>

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)
**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:*

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
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<tr>
<td></td>
<td></td>
<td>Maximum Age Limit</td>
<td>No Maximum Age Limit</td>
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<td>Aged or Disabled, or Both - General</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Aged</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled (Physical)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Disabled (Other)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Injury</td>
<td></td>
<td>0</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medically Fragile</td>
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<tr>
<td>Technology Dependent</td>
<td></td>
<td></td>
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<tr>
<td>× Intellectual Disability or Developmental Disability, or Both</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>× Autism</td>
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</tr>
<tr>
<td>Developmental Disability</td>
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<tr>
<td>Intellectual Disability</td>
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<tr>
<td>Mental Illness</td>
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</tr>
<tr>
<td>Serious Emotional Disturbance</td>
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**b. Additional Criteria.** The state further specifies its target group(s) as follows:
1. Meet the criteria for placement in a Traumatic Brain Injury Rehabilitation Facility (TBIRF) or hospital;
2. Be 0 to 64 years of age;
3. Be a resident of the state of Kansas;
4. Be financially eligible for Medicaid;
5. Have active habilitation/rehabilitation needs or a need related to the BI for therapies to maintain independent living skills; and
6. Have a documented medical diagnosis of a Traumatic Brain Injury or Acquired Brain Injury (TBI or ABI). Brain Injuries due to a chromosomal or congenital diagnosis do not qualify for the BI waiver.
7. For participants between the ages of 4-64, must meet level of care eligibility based on the State approved Functional Eligibility Instruments. The Pediatric assessment will be conducted on children ages 4 to 17.
8. To qualify under a BI diagnosis for ages 0 to 3, the participant must have documentation from a physician indicating the BI diagnosis.

Participants turning 65 while receiving BI waiver services may continue receiving services as long as the participant continues to demonstrate habilitative/rehabilitative progress.

Any participant who does not show habilitative/rehabilitative process in waiver services, including those participants who are approaching the age of 65, may be eligible to transition to another waiver program as described in the KDADS BI Transition Policy, provided the participant meets all program, functional, and financial eligibility criteria to transition to the waiver program.

In order to be eligible for the BI waiver, individuals must have a diagnosis of a BI.

According to State Statute (K.S.A. 39-1801 et seq.) the disability must be diagnosed before the age of 22 to qualify as a developmental disability, regardless of the cause of the disability. Some individuals with a brain injury will have a permanent deficit. Those who end up with a permanent deficit due to the brain injury, and the injury is acquired before the age of 22, may be diagnosed with a developmental disability. In those cases, the individual may be assessed for programmatic and functional eligibility for the IDD waiver to determine if the IDD waiver can provide the supports needed to ensure the individual can remain in the community.

The contracted assessor is responsible for the referral and intake of applicants for the BI program. The assessor screens for reasonable indicators of program eligibility and conducts a functional eligibility assessment to determine if the participant meets program level of care threshold. Final eligibility approval for admission to the BI program is subject to Program Manager’s review and approval. If the level of care threshold is met, the BI Program Manager will review BI supporting documentation to determine whether the injury/diagnosis meets the program definition of acquired or traumatic brain injury. The Program Manager is responsible for ensuring the documentation supports the injury is either a traumatic or acquired brain injury in accordance with program requirements. The State will require a licensed medical professional assessment (for example, physician or neuropsychologist) for documentation that does clearly support a brain injury.

If a brain injury is obtained prior to the age of 22, the individual may be considered developmentally disabled and may be referred to the Community Developmental Disability Organizations (CDDOs) prior to BI screening. CDDOs are required to assess all persons with developmental disabilities for the IDD Program.

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:
Participants who turn 65 while receiving BI waiver services may continue receiving services as long as the participant continues to demonstrate habilitative/rehabilitative progress.

Any participant who does not show habilitative/rehabilitative process in waiver services, including those participants who are approaching the age of 65, may be eligible to transition to another waiver program as described in the KDADS BI Transition Policy, provided the participant meets all program, functional, and financial eligibility criteria to transition to the waiver program.

The policy requires the request to transition be submitted to KDADS a minimum of 30 days prior to the transition date (I.G.). The scope of services is determined by the functional assessment for the waiver the participant is transitioning to (II.H.) and the MCO’s needs assessment conducted prior to updating the Person-Centered Service Plan for the participant. It is the responsibility of the MCO to plan for the transition. The TBI Transition policy defines the minimum requirements the MCO must discuss with the participant related to differences in services, reimbursement rates for workers and value-added services (II.B.)

The TBI Transition policy can be accessed for your review at the following location https://kdads.ks.gov/docs/default-source/csp/hcbs/hcbs-policies/final-policies/tbi-policies/e2019-009-tbi-waiver-transition-policy.pdf?sfvrsn=9aae04ee_4 under the Final Policies heading and under the TBI link.

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.

Specify:

[ ]

07/05/2023
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:

[Blank space]

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>723</td>
</tr>
<tr>
<td>Year 2</td>
<td>723</td>
</tr>
<tr>
<td>Year 3</td>
<td>723</td>
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<tr>
<td>Year 4</td>
<td>723</td>
</tr>
<tr>
<td>Year 5</td>
<td>723</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
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<tr>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Institutional Stay</td>
</tr>
<tr>
<td>WORK Program Transitions</td>
</tr>
<tr>
<td>Institutional Transitions</td>
</tr>
<tr>
<td>Military Inclusion</td>
</tr>
</tbody>
</table>

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**Purpose** *(provide a title or short description to use for lookup):*

**Temporary Institutional Stay**

**Purpose** *(describe):*

The state reserves capacity to maintain continued waiver eligibility for participants who enters into an institution such as a hospital, or TBIRF for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 consecutive days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Participants who remain in the institution following the two month allotment will be terminated from the HCBS program. Any time after 90 consecutive days, the participant can choose to transition to the community following the process in the HCBS Institutional Transition policy.

Describe how the amount of reserved capacity was determined:

- The state projects this number.

**The capacity that the State reserves in each waiver year is specified in the following table:**

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>150</td>
</tr>
<tr>
<td>Year 2</td>
<td>150</td>
</tr>
<tr>
<td>Year 3</td>
<td>150</td>
</tr>
<tr>
<td>Year 4</td>
<td>150</td>
</tr>
<tr>
<td>Year 5</td>
<td>150</td>
</tr>
</tbody>
</table>
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 BI program participants who have participated in the WORK program to transition to the BI Waiver in accordance with the WORK Transition policy.

Describe how the amount of reserved capacity was determined:

This is a projected reserve capacity.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>

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):

**Institutional Transitions**

**Purpose** (describe):

The State reserves capacity for individuals transitioning from an approved institutional setting to the BI Waiver in accordance with the HCBS Institutional Transition Policy.

Describe how the amount of reserved capacity was determined:

Institutional transition reserve capacity is based upon historical experience as to people who have chosen to transition from an approved institutional setting to the BI waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
</tbody>
</table>
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 BI waiver in accordance with the Military Inclusion policy.

Describe how the amount of reserved capacity was determined:

There are no data to support this projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>

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. BI waiver eligibility criteria are defined in the KDADS Brain Injury Eligibility Policy.
2. The HCBS Institutional Transition policy identifies the process and procedures for allowing eligible individuals discharging from an approved institutional setting to access the BI waiver.
3. The Military Inclusion policy identifies the process and procedures for eligible military participants and their immediate dependent family members (as defined by IRS) to access BI waiver services.
4. The KDADS WORK Transition policy details the process for individuals to access the waiver from the WORK program.

Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. In the event there is a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the waiting list remains with the State (KDHE and KDADS).

1. Participants may supersede the waiting list if they meet any one of the following groups:
2. Participants transferring directly from another HCBS waiver;
3. Participants transferring directly from the WORK program;
4. Applicants identified and approved as Crisis Exceptions to the waiting list as established by Kansas Department for Aging and Disability Services/ Community Services and Program Commission (KDADS);
5. Participants exiting a Medicaid approved nursing facility through the Institutional Transition program, who previously gained access in this manner, will now gain access under reserve capacity;
6. Military participants and their immediate dependent family members (as defined by IRS) who have been determined program eligible may bypass waitlist upon approval by KDADS if the individual meets the following criteria:
   a. A resident of Kansas or has maintained residency in Kansas as evidence by tax return or other documentation demonstrating proof of residency
   b. Must be active or recently separated (within 30 days) military personnel or dependent family members who are eligible to receive TriCare Echo
   c. Have been receiving Tricare Echo prior to separation from the military
   d. Received an honorable discharge as indicated on the DD form 214

For the purpose of the military inclusion, IRS defines immediate family as a spouse, child, parent, brother or sister of the individual in the military (IRS 1.25.1.2.2).

All individuals are held to the same criteria when qualifying for a crisis exception as in accordance with statewide policies and guidelines.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. **State Classification.** The state is a *(select one):*
2. Miller Trust State.
   Indicate whether the state is a Miller Trust State (select one):
   - No
   - Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. Check all that apply:

   "Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)"

   - Low income families with children as provided in §1931 of the Act
   - SSI recipients
   - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
   - Optional state supplement recipients
   - Optional categorically needy aged and/or disabled individuals who have income at:
     - Select one:
       - 100% of the Federal poverty level (FPL)
       - % of FPL, which is lower than 100% of FPL.
     - Specify percentage:
   - Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
   - Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
   - Medically needy in 209(b) States (42 CFR §435.330)
   - Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
   - Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)
     - Specify:

     "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.

07/05/2023
Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:
  - Select one:
    - 300% of the SSI Federal Benefit Rate (FBR)
    - A percentage of FBR, which is lower than 300% (42 CFR §435.236)
      - Specify percentage: 
    - A dollar amount which is lower than 300%.
      - Specify dollar amount: 

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

- Medically needy without spend down in 209(b) States (42 CFR §435.330)

- Aged and disabled individuals who have income at:
  - Select one:
    - 100% of FPL
    - % of FPL, which is lower than 100%.
      - Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)
  - Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.
Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

- Use spousal post-eligibility rules under §1924 of the Act.
  (Complete Item B-5-b (SSI State) and Item B-5-d)

- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

- The following standard included under the state plan

  Select one:

  - SSI standard
  - Optional state supplement standard
  - Medically needy income standard
  - The special income level for institutionalized persons

  (select one):

  - 300% of the SSI Federal Benefit Rate (FBR)
  - A percentage of the FBR, which is less than 300%

  Specify the percentage:  

  - A dollar amount which is less than 300%

  Specify dollar amount:  

  - A percentage of the Federal poverty level
Specify percentage: 

- Other standard included under the state Plan
  Specify:

- The following dollar amount
  Specify dollar amount:  
  If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:
  Specify:

- Other
  Specify:

  ii. Allowance for the spouse only (select one):
  - Not Applicable
  - The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
    Specify:

  Specify the amount of the allowance (select one):
  - SSI standard
  - Optional state supplement standard
  - Medically needy income standard
  - The following dollar amount:
    Specify dollar amount:  
    If this amount changes, this item will be revised.
  - The amount is determined using the following formula:
    Specify:

  iii. Allowance for the family (select one):
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:

- Health insurance premiums, deductibles and co-insurance charges
- 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.
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: [Blank]

The following dollar amount:

Specify dollar amount: [Blank] If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

[Blank]

Other

Specify:

300% of SSI

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:
- Allowance is the same
- Allowance is different.

Explanation of difference:

[Blank]

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified
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.*


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.*


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.*


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: [ ]

ii. Frequency of services. The state requires (select one):

- The provision of waiver services at least monthly
- Monthly monitoring of the individual when services are furnished on a less than monthly basis

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

---

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By a government agency under contract with the Medicaid agency.

*Specify the entity:*

The designated ADRC is responsible for evaluation and reevaluations.

- Other

*Specify:*

---

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:
Qualifications of functional eligibility assessors:

Four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the contractor; or a Registered Nurse licensed to practice in the state of Kansas. The contractor is responsible for verifying assessor experience, education and certification requirements are met for assessors identified. The contractor must maintain these records for five (5) years following termination of employment.

Functional eligibility assessors must attend initial certification and recertification training sessions according to KDADS’ Policy. Functional eligibility assessors must successfully complete MFEI and Kansas Aging Management Information System (KAMIS) training prior to performing any functional eligibility assessment.

A functional eligibility assessor that has not conducted any assessments within the last six months must repeat the training and certification requirements for the Medicaid Functional Eligibility Instrument (MFEI).

KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all MFEI assessors. KDADS shall provide training materials and written documentation of successful completion of training. Assessors must participate in all state-mandated trainings to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by KDADS. Tracking staff training is the responsibility of the contractor and should be recorded in the manner required by KDADS.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state’s level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care criteria
1. For ages 0-3, level of care is based on a physician’s diagnosis of BI
2. For ages 4-64, individuals with BI must meet the level of care required for Traumatic Brain Injury Rehabilitation Facility placement or Hospital, determined by the Medicaid LTC threshold score for BI using the State’s Functional Eligibility Instruments (MFEI).

The MFEI is an assessment of an individual's capacity for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The MFEI measures an individual's behavioral/emotional deficits and cognitive limitations that will be critical to the development of a participant’s Person-Centered Service Plan. Kansas uses the MFEI, based on the InterRAI standardized assessment instrument, for the FE, IDD, PD and BI waivers. The InterRAI tool is diagnosis neutral which allows Kansas to use the tool across multiple waivers. The BI waiver uses a youth InterRAI tool, the youth MFEI for ages 4-17, that accommodates for differences in participant age but remains diagnosis neutral. By using this approach, approved transitions between waivers are more effective and support needs are more accurately identified.

The functional eligibility criteria is the same for initial assessments and annual reassessments.

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
The assessing entity shall perform conflict free functional eligibility assessments. The level of care criteria utilized for initial assessments of BI waiver participants and yearly reassessments of participants is the level of care criteria utilized by TBIRFs and hospitals. The contracted assessors will screen for reasonable indicators of meeting the level of care eligibility prior to administering the functional eligibility instrument. The level of care assessment and reassessment process is conducted by qualified assessors contracted with the State. Information used to determine scores and other eligibility criteria can come from a variety of sources. The participant is the primary source of information. The functional eligibility contractor uses interview techniques that are considerate of any limitations the participant might have with hearing, eyesight, cognition, etc. Family members and other individuals who might have relevant information about the participant can also be interviewed. The contracted assessors may also submit clinical records.

The participant must show the capacity to make progress in their habilitative/rehabilitative progress toward developing or maintaining their independent living skills. Progress is evaluated every six months or more frequently as deemed necessary by the MCO or as requested by the participant. S.M.A.R.T. goals, developed by the provider, individual and MCO, are used to track habilitative and rehabilitative progress and maintenance of independent living skills.

If aged 21 or younger, a BI waiver participant must have a KAN-Be-Healthy (EPSDT) screening completed on an annual basis.

All community referrals may contact the contracted assessing entity directly. The contractor conducts a Standard Intake which documents the reasonable indicators for meeting the level of care criteria. Once the intake staff completes the Standard Intake, they will forward the referral to the functional eligibility assessor. The assessor will schedule face to face visit to conduct a functional eligibility assessment using the State approved FEI. The assessor will submit the completed assessment and supporting documentation to the KDADS system of record. If additional documentation is needed, KDADS will request additional documentation from the functional assessor or the participant as necessary. The KDADS BI Program Manager will review the submitted documentation and render an eligibility determination.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (specify):
Timely re-evaluation requirements, as stated in the 1915(c) waiver are also included in the State's contract with the assessing entity. Assurance that timely re-evaluations are conducted are monitored through the KDADS quarterly quality review process. In the event the contractor does not meet the requirements, KDADS issues a corrective action plan which requires the contractor to detail their remediation strategy to come into compliance. The contractor receives a monthly reassessment report from KDADS with a list of all waiver participants that have assessments expiring within 30 days.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and/or electronically retrievable documentation of all evaluations and reevaluations is maintained in the Kansas Assessment Management Information System (KAMIS).

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 newly enrolled waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency's data systems and Managed Care Organizations encounter data

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b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care Determination

N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care Determination

D=Number of waiver participants who received Level of Care redeterminations

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Operating agency’s data systems: “Kansas Assessment Management Information (KAMIS) System or its related web applications”

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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

\[
N = \text{Number of waiver participants whose Level of Care determinations used the approved screening tool}
\]

\[
D = \text{Number of waiver participants who had a Level of Care determination}
\]

**Data Source** (Select one):

- Other
  - If 'Other' is selected, specify:

**Record reviews**

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Contracted assessors participate in analysis of this measure's results as determined by the State operating agency:

- Annually
- Continuously and Ongoing
- Other

Performance Measure:

Number and percent of all Level of Care (LOC) determinations made where the LOC criteria was accurately applied

- N=Number of all Level of Care (LOC) determinations made where the LOC criteria was accurately applied
- D= Number of all Level of Care (LOC) determinations

Data Source (Select one):

- Other

If ‘Other’ is selected, specify:
## Record Reviews

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- Contracted assessors participate in analysis of this measure’s results as determined by the State operating agency

| Frequency of data aggregation and analysis (check each that applies): |  
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| Continuously and Ongoing | Other
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### 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

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Confidence Interval = |
| Other Specify: | Annually | Stratified
Describe Group: |
| Contracted assessors | × Continuously and Ongoing | Other
Specify: |
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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 state’s contracted assessor will be monitored on an ongoing basis to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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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:

1. informed of any feasible alternatives under the waiver; and
2. 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).

The contracted functional assessor informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the State approved choice form. The form or forms are available to CMS upon request.

Additionally, the MCO confirms choice of either institutional or home and community-based waiver services utilizing the State approved choice form.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

BI Waiver Participant Choice forms are documented and maintained by the functional assessor and the participant's chosen KanCare MCO in the participant's case file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information. This information is captured in the demographic section of the standard intake completed by the contracted assessors prior to completing the functional eligibility assessment.

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 participant in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contact 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:

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<td>Occupational Therapy</td>
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<td>Physical Therapy</td>
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<td>Financial Management Services</td>
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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):

HCBS Taxonomy:

Category 1: 08 Home-Based Services
- Sub-Category 1: 08030 personal care

Category 2:
- Sub-Category 2:

Category 3:
- Sub-Category 3:

Service Definition (Scope):

Category 4:
- Sub-Category 4:
Personal Care Services (PCS) includes supports for the participant in the following areas:

1. Activities of Daily Living (ADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy.
2. Health maintenance activities (HMA) in accordance with the Personal Care Services and Limitations policy.
3. Instrumental Activities of Daily Living (IADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy, and consistent with the assessed need in the participant’s Person-Centered Service Plan.
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 will occur where necessary to meet the participant's needs. PCS performed should be specific to the needs of the waiver recipient as reflected in the Person Centered Service Plan.

**Laundry:**
The waiver participant has documented incontinence issues creating excessive laundry. PCS shall only be authorized for the time spent providing assistance with the participant’s excessive laundry.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Services are limited to the assessed level of service need, as specified in the Person-Centered Service Plan, up to 12 hours per 24-hour day. The need to exceed the maximum service limit is subject to approval by the participant's MCO.

The MCO may authorize services exceeding the 12 hours per 24-hour day accommodation if the participant meets one or more of the following criteria:
1. The additional request for PCS is critical to the remediation of the participant’s abuse neglect, exploitation, or domestic violence issue.
2. The additional request for PCS is critical to the participant’s ability to remain in the community in lieu of an institution.
3. The time additional request for PCS is a necessary support in order for the participant to remain in the community within the first three months of his/her return to the community from a prolonged stay (greater than 90 days) in an institution.

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 person may have several personal assistants providing him/her care on a variety of days at a variety of times, but a person may not have more than one assistant providing care at any given time. Person-Centered Service Plans for which it is determined that the provision of Personal Services would be a duplication of services will not be approved. The MCO will not make payments for multiple claims filed for the same time on the same date of service.

The services under the Brain Injury waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. PCS is limited to those services 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.

Children receiving care in licensed foster care settings do not have the option to self-direct services. All services must be provided through the agency directed service model.

While Federal rules generally prohibit payments to legally responsible relatives for Personal Care Services, Kansas does allow such payments under the circumstances described in Appendix C-2-d. Legally responsible individuals who have a duty under State law to care for another person include:
(a) the parent (biological or adoptive) of a minor child; or the guardian of a minor child who must provide care to the child; or
(b) a spouse of a waiver participant

Service Delivery Method (check each that applies):

- [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
- Relative
- Legal Guardian

Provider Specifications:

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<tbody>
<tr>
<td>Individual</td>
<td>Direct Support Worker</td>
</tr>
<tr>
<td>Agency</td>
<td>Licensed Home Health Agency</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services
### Provider Specifications for Service

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Personal Care

**Provider Category:**  
- Individual

**Provider Type:**  
- Direct Support Worker

**Provider Qualifications**

- **License** *(specify):*
  - n/a

- **Certificate** *(specify):*
  - n/a

- **Other Standard** *(specify):*
  
  A. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider  
  B. Must have a High School Diploma or equivalent OR be at least eighteen years of age or older;  
  C. Complete KDADS Approved Skill Training requirements.  
  D. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant, legal representative or qualified medical provider.  

  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: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Personal Care

**Provider Category:**  
- Agency

**Provider Type:**  
- Licensed Home Health Agency

**Provider Qualifications**

- **License** *(specify):*  

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07/05/2023
K.S.A. 65-5001 et seq.

Certificate (specify):

n/a

Other Standard (specify):

Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).

a. Must have a High School Diploma/GED OR be at least eighteen years of age or older
b. Complete KDADS Approved Skill Training requirements.
c. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant, legal representative or qualified medical provider.

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:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

<table>
<thead>
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<th>Category 1:</th>
<th>Sub-Category 1:</th>
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<tr>
<td>11 Other Health and Therapeutic Services</td>
<td>11080 occupational therapy</td>
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</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
</table>
Service Definition (Scope):

Occupational Therapy is a treatment approach that focuses on the effects of injury on the social, emotional, and physiological condition of the participant, and evaluates an individual's balance, motor skills, posture, and perceptual and cognitive abilities within the context of functional, everyday activities. Occupational Therapy helps participants with BI achieve greater independence in their lives by regaining some or all of the physical, perceptual, and/or cognitive skills needed to perform activities of daily living through exercises and other related activities. When skills and strength cannot be adequately developed or improved, Occupational Therapy offers creative solutions and alternatives for carrying out daily activities. This is done by manipulating the participant's environment or by obtaining or designing special adaptive equipment and training the participant in its use. In every case, the goal of Occupational Therapy is to help people develop the living skills necessary to increase independence and, thus, enhance self-satisfaction with the person's quality of life.

Occupational Therapy waiver services are provided when the limits of the approved Occupational Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participant's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their habilitation/rehabilitation.

Occupational therapy is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This waiver service is only provided to individuals age 21 and over. All medically necessary Occupational Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Occupational Therapy is limited to those services 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.

A maximum of 3,120 units per calendar year (1 unit=15 minutes), either alone or in combination with any other BI Waiver rehabilitation therapy services, may be allocated.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them participant under EPSDT in addition to the extended State Plan service. EPSDT-eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT.

Occupational Therapy is available through the BI waiver no sooner than six months after the BI occurs. (Prior to this, OT is available as a Medicaid State Plan service.)

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services: Personal Care Services (PCS) and Transitional Living Specialist (TLS)

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Occupational Therapist</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

- **Service Type**: Extended State Plan Service
- **Service Name**: Occupational Therapy

**Provider Category**: Individual

**Provider Type**: Occupational Therapist

**Provider Qualifications**

- **License (specify)**:
  
  Licensed by the Kansas Board of Healing Arts (K.S.A. 65-5401 et seq). All services must be provided in accordance with applicable licensing statutes and regulations.

- **Certificate (specify)**:

- **Other Standard (specify)**:
Complete KDADS approved training curriculum.
40 hours of training in BI or one year of experience working with individuals with BI.

In compliance with State statutes and regulations (KSA 65-5419, KAR 100-54-10) occupational therapy may be provided by an occupational aide, occupational therapy tech, or occupational therapy paraprofessional (K.S.A. 65-5419) under the supervision of an enrolled licensed occupational therapist.

The occupational therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The licensed occupational therapist is responsible for providing, upon request from the State, the following:
- Comprehensive list of the selected tasks that will be performed by the aide/tech/paraprofessional
- Documentation of training completed by the aide/tech/paraprofessional
- Documentation of evidence to support the aide/tech/paraprofessional’s competence at completing the selected tasks

Requirements for occupational aide/occupational therapy tech/occupational therapy paraprofessional:
- Must have the appropriate level of education and certification (KAR 100-54-2 & 100-54-3)
- Must be at least eighteen years of age or older
- Must reside outside of the waiver recipient’s home
- Must be a Medicaid enrolled provider or be an employee of a Medicaid enrolled provider

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

**Entity Responsible for Verification:**
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171

**Frequency of Verification:**
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

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**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:**
Extended State Plan Service

**Service Title:**
Physical Therapy

**HCBS Taxonomy:**
Service Definition (Scope):
Physical Therapy is a treatment approach that assists individuals with reaching their highest level of motor functioning and mobility. Through Physical Therapy, people with BI receive treatment to move and perform functional activities in their daily lives and to help prevent conditions associated with loss of mobility through fitness and wellness programs that achieve healthy and active lifestyles. Treatment may involve intensive work in a variety of areas including standing, sitting, walking, balance, muscle tone, endurance, strength, and coordination. Physical Therapy also identifies and instructs the individual in the use of special equipment, when necessary, that can help the individual adapt to limited physical functioning and move more freely and independently in their environment.

Physical Therapy waiver services are provided when the limits of the approved Physical Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participants needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their habilitation/rehabilitation.

Physical Therapy is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This waiver service is only provided to individuals age 21 and over. All medically necessary Physical Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Physical Therapy is limited to those services 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.

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy services may be allocated.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service. EPSDT eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT.

Physical Therapy is offered through the BI waiver no sooner than six months after the BI occurs. (Prior to this, it is available as a Medicaid State Plan service.)

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:
- Personal Care Attendant (PCA) and Transitional Living Specialist (TLS)
- Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
- Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)
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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Physical Therapist</td>
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</table>

Appendix C: Participant Services

**C-1/C-3: Provider Specifications for Service**

<table>
<thead>
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<th>Service Type: Extended State Plan Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name: Physical Therapy</td>
</tr>
</tbody>
</table>

Provider Category:

- Individual

Provider Type:

- Physical Therapist

Provider Qualifications

**License (specify):**

Licensed by the Kansas Board of Healing Arts (K.S.A. 65-2901 et seq). All services must be provided in accordance with applicable licensing statutes and regulations.

**Certificate (specify):**


**Other Standard (specify):**
Complete KDADS approved training curriculum.
40 hours of training in BI or one-year experience working with individuals with BI.

In accordance with statutes and regulations (KAR 100-29-16 & KSA 65-2909, 65-2010, 65-2918), physical therapy may be provided by a physical therapist assistant under the supervision of an enrolled licensed physical therapist provider in accordance with applicable statutes and regulations.

The physical therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The licensed physical therapist is responsible for providing, upon request from the State, the following:
- Comprehensive list of the selected tasks performed by the physical therapy assistant
- Documentation of education, training, experience, and skill level of the physical therapist assistant
- Documentation of the setting in which the care is being delivered to the participant
- Documentation of the complexity and acuteness of the participant condition or health status

Requirements for physical therapy assistant:
- Must have the appropriate level of education and certification (K.A.R. 100-29-2, 100-29-3 & KSA 65-2909, 65-2910)
- Must be at least eighteen years of age or older
- Must reside outside of the waiver recipient’s home
- Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled provider.

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:
Extended State Plan Service

Service Title:
Speech and Language Therapy

HCBS Taxonomy:
Speech-Language Therapy is the treatment of speech and/or language disorders, i.e., problems with the actual production of sounds and difficulty understanding or putting words together to communicate ideas. Assessment and treatment of persons with BI may include the areas of language (listening, talking, reading, writing), cognition (attention, memory, sequencing, planning, time management, problem solving), motor speech skills and articulation, and conversational skills. Speech-language therapy can also address issues related to swallowing and respiration.

Goals for the person with BI will depend on the participant's level of functioning, with the overriding focus being to regain lost skills and/or learn ways to compensate for abilities that have permanently changed so as to help the individual achieve the greatest level of independence possible.

Speech-Language Therapy waiver services are provided when the limits of the approved Speech-Language Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participants needs as identified by the licensed provider and in keeping with the habilitative /rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their rehabilitation.

To avoid any overlap of services, Speech-Language Therapy is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. BI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

Speech Language Therapy is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This waiver service is only provided to individuals age 21 and over. All medically necessary Speech and Language Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Speech and Language Therapy is limited to those services 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.

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy services may be allocated.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service. EPSDT eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT

Speech-Language Therapy is offered through the BI waiver no sooner than six months after the BI occurs. (Prior to this, it is available as a Medicaid State Plan service.)

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:
- Direct Support Worker (DSW) and Transitional Living Specialist (TLS)
- Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
- Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)

**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:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Speech/Language Therapist</td>
</tr>
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</table>

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Extended State Plan Service  
**Service Name:** Speech and Language Therapy

**Provider Category:**
- Individual

**Provider Type:**
- Speech/Language Therapist

**Provider Qualifications**

**License (specify):**

Licensed by Kansas Department for Aging and Disability Services. All services must be provided in accordance with applicable licensing statutes and regulations. (K.S.A. 65-6501 et seq & K.A.R. 28-61)

**Certificate (specify):**
Other Standard (specify):

Complete KDADS approved training curriculum.
40 hours of training in BI or one year experience working with individuals with BI.

In compliance with statutes and regulations (KSA 65-6501 and KAR 28-61), speech/language therapy may be provided by a speech-language pathology assistant under the supervision of an enrolled licensed speech-language pathologist provider in accordance with applicable statutes and regulations.

The speech/language therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The speech-language pathologist is responsible for providing, upon request from the State, the following:
- File documentation of the assistant’s qualifications and training
- Documentation of performance level of the assistant
- Comprehensive list of the tasks performed by the assistant

Requirements for speech-language pathology assistant:
- Must have the appropriate level of education and certification (KAR 28-61-8)
- Must be at least eighteen years of age or older
  - Must reside outside of the waiver participant’s home
  - Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled provider

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services
Alternate Service Title (if any):

HCBS Taxonomy:

<table>
<thead>
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<th>Category 1:</th>
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<td>12 Services Supporting Self-Direction</td>
<td>12010 financial management services in support of self-direction</td>
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<tr>
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<table>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
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</table>

Service Definition *(Scope)*:

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 but not limited to 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 Kansas Medical Assistance Program (KMAP) manual details the responsibilities of the FMS provider, waiver participant and the MCO. FMS is an agency directed service.

MCO Responsibilities
The FMS Kansas Medical Assistance Program (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 the 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 and 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 that they 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 Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider.

FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:
• Verification and processing of time worked and the provision of quality assurance;
• Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers’ compensation insurance requirements; making tax payments to appropriate tax authorities;
• Performance of fiscal accounting and expenditure reporting to the participant or participant’s representative and the state, as required.
• Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.
The FMS provider is responsible for Information and Assistance functions including but not limited to:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant’s representative in managing and directing services;
2. Assistance to the participant or participant’s representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

Participant Responsibilities

1. Act as the employer for the Direct Support Workers (DSW), or designate a representative to manage or help manage Direct Support Workers (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 Direct Support Worker(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 and authorized Person-Centered Service Plan or others as identified and/or are appropriate.
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. Process for reporting work-related injuries incurred by the DSW(s) to the FMS provider.
14. Develop an emergency worker back-up plan in in case a substitute DSW is ever needed on short notice or as a back-up (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 was is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers (DSWs). Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.
The FMS provider is responsible for Information and Assistance functions including but not limited to:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant’s representative in managing and directing services;
2. Assistance to the participant or participant’s representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

Participant Responsibilities

1. Act as the employer for the Direct Support Workers (DSW), or designate a representative to manage or help manage Direct Support Workers (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 Direct Support Worker(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 and authorized Person-Centered Service Plan or others as identified and/or are appropriate.
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. Process for reporting work-related injuries incurred by the DSW(s) to the FMS provider.
14. Develop an emergency worker back-up plan in in case a substitute DSW is ever needed on short notice or as a back-up (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 was is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers (DSWs). Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Access to this service is limited to participants who chose to self-direct some or all of the service(s) when self-direction is offered.

FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.

**Service Delivery Method** *(check each that applies):*

- [x] Participant-directed as specified in Appendix E
- [x] Provider managed

**Specify whether the service may be provided by** *(check each that applies):*

- [x] Legally Responsible Person
- [x] Relative
- [x] Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Agency</td>
<td>Enrolled Medicaid Provider</td>
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**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Supports for Participant Direction  
**Service Name:** Financial Management Services

**Provider Category:**
- Agency

**Provider Type:**
- Enrolled Medicaid Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**
Enrolled FMS providers will furnish Financial Management Services according to Kansas model.

Organizations interested in providing Financial Management Services (FMS) are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment in KMAP to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually and approval is subject to satisfactory completion of the required GAAP audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in KSA 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 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.

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 (I/DD only)
• Secretary of State Certificate of Corporate Good Standing
• W-9 form
• Proof of Liability Insurance
• Proof of Workers Compensation insurance
• Copy of the most recent quarterly operations report or estimate for first quarter operations
• Financial statements (last 3 months bank statements or documentation of line of credit)
• Copy of the organization’s Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
• Including process for conducting background checks
• Process for establishing and tracking workers wage with the participant

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
**Assistive Services**

**HCBS Taxonomy:**

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**Service Definition (Scope):**

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
</table>
Assistive Services are those services which meet a participant’s assessed need of a participant with a disability by modifying or improving a participant’s home through environmental 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. Assistive services may be substituted for Personal Services only when they have been identified as a cost-effective alternative to Personal Services on the participant’s Person-Centered Service Plan. (Examples: Tangible equipment or hardware such as technology assistance devices, adaptive equipment, or environmental modifications)

Assistive Services is available, with prior authorization from the participant’s chosen KanCare MCO, to HCBS/BI waiver participants for situations defined as “critical.” Critical situations are defined as one of the following: The following conditions must be met:

1. The participant is returning to the community from an institutional setting, (i.e., nursing facility, TBI rehabilitation facility, or other medical facility). The Assistive Service must be critical to the participant’s ability to return to and remain in the community and must be a necessary expenditure within the first three months of the participant’s return to the community. OR:

2. A BI waiver participant is in a situation where there is:
   • Confirmation by Adult Protective Services that the participant is a recent victim of abuse, neglect or exploitation;
   • Confirmation by Children and Family Services that the participant is a recent victim of abuse or neglect; or
   • Documentation showing that the participant is a recent victim of domestic violence. OR:

3. There is a change in condition which creates a new critical need for an assistive service to remain in the community.

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 that the landlord will: (1) maintain the modifications for a period of not less than three years; and will(2) 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.

Reimbursement for this service is limited to the participant’s assessed level of need 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 or the purchase. Participants will have complete access to choose any qualified provider 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.
Children will receive all medically necessary services. Assistive Services is an agency directed service.

The services under the Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

In order to align this waiver service with federal requirements, the state will complete system changes to unbundle Assistive Services and submit a waiver amendment no later than May 2020 in accordance with the timeline agreed upon with CMS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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.

1. Assistive services may be substituted for Personal Care Services (PCS) only when Assistive Services have been identified as a cost-effective alternative to PCS on the participant’s Person-Centered Service Plan.

2. Children who may require Assistive Services and whose situation does not meet critical situation criteria may receive services through the Medicaid State Plan if medically necessary.

The MCOs are required to authorize services to meet participants needs. They have the option to authorize any services necessary for health and safety.

Assistive Services are limited to the participant’s assessed level of service need as specified in the participant’s Person-Centered Service Plan. There is a $7,500 maximum lifetime expenditure, across waivers with the exception of the I/DD Waiver. This limit was set based on the available waiver funds appropriated by the Kansas Legislature.

**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:**

<table>
<thead>
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<th>Provider Category</th>
<th>Provider Type Title</th>
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<tr>
<td>Individual</td>
<td>Contractor</td>
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<tr>
<td>Agency</td>
<td>DME Provider</td>
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</table>

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Service</td>
<td>Assistive Services</td>
</tr>
</tbody>
</table>

**Provider Category:**

- [ ] Agency

**Provider Type:**

Center for Independent Living
Provider Qualifications

License (specify): 

Certificate (specify): 

Other Standard (specify): 

Medicaid-enrolled provider
Applicable work must be performed according to local and county codes
General contractors must provide proof of certificate of Worker's Compensation and General Liability Insurance

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.
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: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:
Individual

Provider Type:
Contractor

Provider Qualifications

License (specify):  

Certificate (specify): 

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Other Standard (specify):

- Contractor must affiliate or subcontract with a recognized Center for Independent Living (CIL) or licensed Home Health Agency (as defined in K.S.A. 65- 5001 et seq.)

- Applicable work must be performed according to local and county codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:
Agency

Provider Type:
DME Provider

Provider Qualifications

License (specify):
Home Health Agency license
State Pharmacy License
Rural Health Clinic License
Licensed Welder.

Certificate (specify):
n/a

Other Standard (specify):
As described in K.A.R 30-5-59
As described in K.S.A. 65-1626
Medicaid-enrolled provider
Home modifications must be performed according to local and county codes

DME as a part of Assistive Services may be provided by all of the following:
- Licensed Home Health Agency
- Durable Medical Equipment provider
- Pharmacy
- Rural Health Clinic (medical supplies only)
- Welding Shop (oxygen only)

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

A provider of services for a participant in foster care, adopted, part of KanBeHealthy, or with special needs may be excluded from the above requirements if a determination is made that a medically necessary piece of durable medical equipment can be cost-efficiently obtained only from a provider not otherwise eligible to be enrolled according to the current program guidelines.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavior Therapy

HCBS Taxonomy:

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<th>Sub-Category 2:</th>
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</table>

07/05/2023
In general, Behavior Therapy applies to the application of findings from behavioral science research to help individuals change in ways that they would like to change. These research-based strategies are used to help increase the quality of life of the individual with BI and decrease problem, self-destructive behavior, such as aggression, property destruction, self-injury, poor anger management, and other behaviors that can interfere with an participant's ability to adapt to and live successfully in the community. Behavior Therapy can involve looking at the participant's early life experiences, long-time internal psychological or emotional conflicts, and/or the participant's personality structure. Generally, however, Behavior Therapy emphasizes the participant's current environment and making positive changes to that environment while improving the participant's self-control using procedures to expand the participant's skills, abilities, and level of independence.

Behavior therapy is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy services.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service.

This waiver service is only provided to individuals age 21 and over. All medically necessary Behavior Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Behavior Therapy is limited to those services 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.

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:

- Personal Care Attendant (PCA) and Transitional Living Specialist (TLS)
- Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
- Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Individual</td>
<td>Behavior Therapist</td>
</tr>
</tbody>
</table>
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Therapy

Provider Category:
- Individual

Provider Type: Behavior Therapist

Provider Qualifications

License (specify):

Licensed by the Kansas Behavioral Sciences Regulatory Board
(K.S.A. 74-5301 et seq. and K.S.A. 65-6301 et seq.)

Certificate (specify):

Providers serving in a school environment can provide these services if the provider has a certification in Special Education by the Kansas State Department of Education. For this circumstance, the provider must have a Master’s degree in Special Education, complete KDADS approved training curriculum, 40 hours of training of one year of experience working with individuals with BI, and comply with State statutes, rules, and regulations. Consistent with the certification/licensing board requirement, a provider meeting these qualifications can only provide services in a school environment.

Other Standard (specify):

Master's degree in a behavioral science field (e.g., psychology, neuropsychology, social work)
Complete KDADS approved training curriculum.
40 hours of training in BI or one year experience working with individuals with BI.

In accordance with State statutes and regulations (KAR 102-2-8 and 102-1-11), behavioral therapy may be provided by an unlicensed assistant under the supervision of an enrolled licensed provider.

The behavior therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The behavior therapy provider is responsible for providing, upon request from the State, the following:
- File documentation of the assistant’s qualifications and training
- Documentation of performance level of the assistant
- Comprehensive list of the tasks performed by the assistant

Requirements for unlicensed behavior therapy assistant:
- Must have the appropriate level of education and certification (KAR 102-1-11 & 102-2-8)
- Must be at least eighteen years of age or older
- Must reside outside of the waiver recipient’s home
- Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled provider

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:
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:
Cognitive Rehabilitation

HCBS Taxonomy:

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</thead>
</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
</table>

Cognitive Rehabilitation is a treatment process in which a person works to alleviate deficits in thinking. In cases of persons with BI, these deficits can include poor attention and concentration, memory loss, difficulty with problem solving, and dysfunctional thoughts and beliefs that can contribute to maladaptive behavior and emotional responses. Through Cognitive Rehabilitation, the individual utilizes methods that aim to help make the most of existing cognitive functioning despite the difficulties they are experiencing through various methods, including guided practice on tasks that reflect particular cognitive functions, development of skills to help identify distorted beliefs and thought patterns, and strategies for taking in new information, such as the use of memory aids and other assistive devices. The goal for the individual receiving Cognitive Rehabilitation is to achieve an awareness of their cognitive limitations, strengths, and needs and acquire the awareness and skills in the use of functional compensations necessary to increase the quality of life and enhance their ability to live successfully in the community.

Cognitive Rehabilitative Therapy is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This waiver service is only provided to individuals age 21 and over. All medically necessary Cognitive Rehabilitation services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Cognitive Rehabilitation is limited to those services 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.

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service. EPSDT eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT.

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:
- Personal Care Attendant (PCA) and Transitional Living Specialist (TLS)
- Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
- Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)

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:

<table>
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<th>Provider Category</th>
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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Rehabilitation

Provider Category: Individual
Provider Type: Cognitive Therapist/Rehabilitation Specialist

Provider Qualifications
License (specify):
Licensed by the Kansas Behavioral Sciences Regulatory Board (K.S.A. 74-5301 et seq. and K.S.A. 65-6301 et seq.)
Certificate (specify):
Providers serving in a school environment can provide these services if the provider has a certification in Special Education by the Kansas State Department of Education. For this circumstance, the provider must have a Master’s degree in Special Education, complete KDADS approved training curriculum, 40 hours of training of one year of experience working with individuals with TBI, and comply with State statutes, rules, and regulations. Consistent with the certification/licensing board requirement, a provider meeting these qualifications can only provide services in a school environment.

Other Standard (specify):

- Master's degree in a behavioral science field (e.g., psychology, neuropsychology, social work) and Complete KDADS approved training curriculum.
- 40 hours of training in BI or one year experience working with individuals with BI.

In accordance with statutes and regulations (KAR 102-2-8 and 102-1-11), cognitive therapy may be provided by an unlicensed assistant under the supervision of an enrolled licensed provider.

The cognitive therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The cognitive therapy provider is responsible for providing, upon request from the State, the following:
- File documentation of the assistant’s qualifications and training
- Documentation of performance level of the assistant
- Comprehensive list of the tasks performed by the assistant

Requirements for unlicensed cognitive therapy assistant:
- Must have the appropriate level of education and certification (KAR 102-2-8 & 102-1-11)
- Must be at least eighteen years of age or older
- Must reside outside of the waiver recipient’s home
- Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled provider

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:

Enhanced Care Services

HCBS Taxonomy:

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</thead>
</table>

<table>
<thead>
<tr>
<th>Category 3:</th>
<th>Sub-Category 3:</th>
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</table>

Service Definition (Scope):

Enhanced Care Services provides non-nursing physical assistance and/or supervision during the consumer’s normal sleeping hours in the participant’s place of residence. This assistance includes, the following: physical assistance or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and prompting to take medication.

Providers will sleep and awaken as identified on the participant’s person-centered service plan and must provide the consumer with a mechanism to gain their attention or awaken them at any time (e.g., a bell or buzzer). Providers must be ready to call a physician, hospital, any identified contact individuals, or other medical personnel should an emergency arise. The scope of and intent behind Enhanced Care Services is entirely different from and therefore not duplicative of services defined as and provided under Personal Services.

The Person-Centered Service Plan must indicate a need for this service that is beyond the need for a Personal Emergency Response System.

Enhanced Care Services can be either an agency directed service or self-directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
To avoid overlap of services, ECS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant’s Person-Centered Service Plan.

The length of service (i.e., one unit) during any 24-hour time period must be at least 6 hours, but hours but cannot exceed twelve hours.
1 unit of service is equal to 6-12 hours within a 24-hour period.
The ECS provider cannot be an individual residing in the home with the participant unless the provider is a legally responsible person and an exception has been granted by the MCO as described below.

ECS cannot be provided by a participant’s legally responsible person (spouse or parent of a minor child). The MCO may grant an exception to allow a legally responsible person to provide ECS when one of the following three circumstances are 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.

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 as detailed in Appendix C.2.E.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Enhanced Care Services provider</td>
</tr>
<tr>
<td>Agency</td>
<td>Enhanced Care Services provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Care Services

Provider Category:

- Individual

Provider Type:

- Enhanced Care Services provider

Provider Qualifications

License (specify):
Certificate *(specify):*

Other Standard *(specify):*

- must be at least 18 years of age
- must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider
- must have the ability to call appropriate individual/organization in case of an emergency and provide the intermittent care the individual may need.
- 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.

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: Provider Specifications for Service**

**Service Type:** Other Service

**Service Name:** Enhanced Care Services

**Provider Category:**

Agency

**Provider Type:**

Enhanced Care Services provider

**Provider Qualifications**

**License *(specify):***

**Certificate *(specify):***

**Other Standard *(specify):***
• must be at least 18 years old
• Agency must be an enrolled Medicaid provider
• must have the ability to call appropriate individual/organization in case of an emergency and provide the intermittent care the individual may need

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:
Home-Delivered Meals Service

HCBS Taxonomy:

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<td>06010 home delivered meals</td>
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<table>
<thead>
<tr>
<th>Service Definition (Scope):</th>
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</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
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</table>

07/05/2023
Home-Delivered Meals Service provides a participant with one (1) or two (2) meals per calendar date. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements. The meals are prepared elsewhere and delivered to the participant’s home. Participants eligible for this service have been determined functionally in need of the Home-Delivered Meals service as indicated by the Functional/Needs Assessment. Meal preparation provided by a BI waiver Personal Care Services provider may be authorized in the participant’s Person-Centered Service Plan for those meals not provided under the Home-Delivered Meals Service. Home Delivered Meal Service is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to participants who require extensive routine physical support for meal preparation as supported by the participant's Functional/Needs Assessment for meal preparation. This service may not be maintained when a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is not duplicative of home-delivered meal service provided through the Older Americans Act, subject to the participant meeting related age and other eligibility requirements, nor is it duplicative of meal preparation provided by attendants through Personal Services.
- This service is available in the participant’s home.
- No more than two (2) home-delivered meals will be authorized per participant for any given calendar date.
- This service must be authorized in the participant’s Person-Centered Service Plan.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Approved and Medicaid-enrolled nutrition provider agency</td>
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</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Delivered Meals Service

Provider Category:
Agency
Provider Type:
Approved and Medicaid-enrolled nutrition provider agency

Provider Qualifications
License (specify):

Certificate (specify):
Other Standard *(specify):*

Provider must have on staff or contract with a certified dietician to assure compliance with KDADS nutrition requirements for programs under the Older Americans Act.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in KSA 39-2009 is not eligible for reimbursement of services under Medicaid funding.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171

**Frequency of Verification:**

The MCOs, with oversight by KDADS, shall verify provider qualifications annually

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**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Medication Reminder Services

**HCBS Taxonomy:**

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<table>
<thead>
<tr>
<th>Service Definition <em>(Scope):</em></th>
<th>Sub-Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 4:</td>
<td></td>
</tr>
</tbody>
</table>
Medication Reminder Services provides a scheduled reminder to a participant when it is time for the participant to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the providers system.

Medication Reminder/Dispenser is a device that houses a participant’s medication and dispenses the medication with an alarm at programmed times.

Medication Reminder/Dispenser Installation is the placement of the Medication Dispenser in a participant’s home.

Education and assistance with all Medication Reminder Services is made available to participants during implementation and on an ongoing basis by the provider of this service.

Medication Reminder Service is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Routine maintenance of rental equipment is the provider’s responsibility.
- Repair/replacement of rental equipment is not covered.
- Rental of equipment is covered.
- Purchase of equipment is not covered.

This service is limited to participants who live alone or who are alone a significant portion of the day, and have no regular informal and/or formal support for extended periods of time, and who otherwise require extensive routine non-physical support including medication reminder services offered through an attendant of Personal Services.

This service is not duplicative of services offered free of charge through any other agency or service. These systems may be maintained on a monthly rental basis even if a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is available in the participant’s home. Medication Reminder service is not provided face-to-face with the exception of the Installation of Medication Reminder/Dispenser.

Installation of Medication Reminder/Dispenser is limited to one installation per participant per calendar year.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Medication Reminder Services Provider/Dispenser Provider/ Dispenser Installation Provider</td>
</tr>
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</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Services

Provider Category:
Agency

Provider Type:

Medication Reminder Services Provider/Dispenser Provider/ Dispenser Installation Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any company providing medication reminder services per industry standards is eligible to contract with KanCare as a Medication Reminder Services.

Medication Reminder Service providers must provide appropriate training to their staff on medication administration and dispensing of medication.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have 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:

Personal Emergency Response System and Installation

HCBS Taxonomy:
Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable participants at high risk of institutionalization to secure help in an emergency. The system is connected to the participant's telephone and programmed to signal a response center once the help button is activated. The participant may wear a portable help button to allow for mobility. PERS is limited to those participants who:
1. live alone, or
2. who are alone for significant parts of the day, and
3. have no regular attendant (formal or informal) for extended periods of time, and
4. who would otherwise require extensive routine supervision.

Personal Emergency Response System and Installation is an agency directed service. The PERS system has a back-up battery that is activated if an emergency situation develops. The back-up battery will activate if there is interference with the landline and connection through the cell phone will remain as long as the cell phone towers are intact. If the system is not functioning properly, the provider will attempt to contact the participant through the PERS system. If unable to communicate with the participant, the provider contacts the participant-selected responders to contact with the participant in a 15-20 minute window. If the PERS provider is unable to reach the responders, then the provider will contact 911/EMS to check on the unresponsive participant. In addition, the PERS system should be checked once a month to ensure that it is functioning properly and the back-up battery is functional. Participants have the ability to turn off/unplug the PERS system; however, turning off the system will trigger an alert to the PERS provider. The provider will follow up with the participant to ensure his/her health and welfare. The PERS provider must receive permission from the participant for the use of the device in the home.

PERS Installation is the placement of electronic PERS devices in a participant's residence. Participants must have an assessed need for a Personal Emergency Response System.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid any overlap of services, PERS is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. BI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

Maintenance of rental equipment is the responsibility of the provider.
Repair/replacement of equipment is not covered.
Rental is covered; purchase is not.
Call lights do not meet this definition.
There is a maximum of two PERS Installations per calendar year.
PERS requires prior authorization based on the assessed need.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

07/05/2023
Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>PERS provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System and Installation

Provider Category:
Agency

Provider Type:
PERS provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):

Must be contracted with the MCO.
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 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 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:
Transitional Living Skills

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
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<tbody>
<tr>
<td>08 Home-Based Services</td>
<td>08010 home-based habilitation</td>
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<table>
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<th>Category 3:</th>
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<table>
<thead>
<tr>
<th>Category 4:</th>
</tr>
</thead>
</table>

Service Definition (Scope):

Transitional Living Skills (TLS) provides community and in-home training and support services designed to prevent and/or minimize chronic disabilities due to the brain injury. The primary purpose of TLS services under the waiver is to provide opportunities for waiver participants to develop and/or re-learn skills necessary to optimize independence and enhance the participant’s quality of life.

Transitional Living Skills are comprehensive in nature and, therefore, address multiple aspects of an participant’s needs and goals to achieve as much independence as possible. Training follows a model in which participants with a BI practice skills in real-life situations in their home and community. TLS services are designed to teach the participant how to become more self-sufficient through the application of these skills, which include: household management, disability and social adjustment, problem-solving, functional communication, self-management, and community living. The need for TLS services are expected to decrease as the participant’s skills increase.

Transitional Living Skills is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
To avoid any overlap of services, TLS services are limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources. BI waiver funding is used as the funding source of last resort and requires prior authorization from the KanCare MCO’s.

TLS can be authorized for up to four hours a day with an annual limit of 3,120 units per year.

BI providers are not permitted to be dual providers for the same participant for the following services:
- Personal Care Services (PCS) and Transitional Living Specialist (TLS)
- Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)

**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:**

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**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Other Service

**Service Name:** Transitional Living Skills

**Provider Category:**

<table>
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<th>Agency</th>
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**Provider Type:**

- Transitional Living Skills Provider

**Provider Qualifications**

**License (specify):**

<table>
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<th>Specify</th>
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</table>

**Certificate (specify):**

<table>
<thead>
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<th>Specify</th>
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</thead>
</table>

**Other Standard (specify):**

<table>
<thead>
<tr>
<th>Specify</th>
</tr>
</thead>
</table>
Individual TLS Specialists must have:

a. Must have a High School Diploma/GED
b. Must be at least eighteen years of age or older
c. Complete KDADS Approved Skill Training requirements.
d. Must reside outside of waiver participant's home;
e. Complete any additional skill training needed in order care for the waiver participant as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO;
f. 28 hours of training in BI

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.

Providers must enroll in KMAP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):

- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.
- As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:
a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All HCBS providers 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 offence as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

The contractor / sub contractor and /or provider agency must provide evidence that required standards have been met or maintained at the renewal of their professional license as required by the KDADS Background Check policy.

The employer shall submit a request for the following checks:
1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver’s license record check through the Kansas Department of Revenue (KDOR)
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)
7. All employees of HCBS provider agencies must undergo background checks.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- No. The state does not conduct abuse registry screening.
- Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All HCBS providers are required to pass DCF abuse registry checks and the Nurse Aide Registry consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, 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.
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:
An adult consumer’s spouse or a minor consumer’s parents can provide services if all other possible options are
exhausted and one of the following extraordinary criteria is met.
(1) Three HCBS provider agencies furnish written documentation that the consumer’s residence
   is so remote or rural that HCBS services are otherwise completely unavailable. (2) Two health care professionals,
   including the attending physician, furnish written documentation that the consumer’s health, safety, or social well-
   being, would be jeopardized. (3) The attending physician furnishes written
documentation that, due to the advancement of chronic disease, the consumer’s means of communication can be
understood only by the spouse or by the parent of a minor child.
(4) Three HCBS providers furnish written documentation that delivery of HCBS services to
   the consumer poses serious health or safety issues for the provider, thereby rendering HCBS services
   otherwise unavailable.
Legally responsible individuals, including legal, adjudicated guardians may provide personal services although they
must contract with KanCare or have an arrangement with an KanCare contracted provider that includes TBI
Personal Services and/or Enhanced Care Services as a service specialty. This allowance in no way supersedes the
family reimbursement restriction pertaining to spouses and parents of minor children noted above. Limitation on
services is governed by the assessed need of the participant.
Assurance that payments are made only for services rendered is provided through documentation in EVV by the
personal care services provider. Other assurance is provided through periodic reviews conducted by the
Surveillance and Utilization Review System unit of the state’s contracted fiscal agent.
A guardian, conservator or A-DPOA is not permitted to provide PCS unless conflict of interest has been mitigated in
accordance with this policy and the Conflict of Interest policy.
If the designation of the appointed representative (guardian, conservator, A-DPOA for health care or an individual
acting on behalf of the participant) is withdrawn, the individual may become the participant’s paid PCS worker after
the next annual review or a significant change in the participant’s needs occurs prompting a reassessment.
Family reimbursement restrictions shall be applied in accordance with K.A.R. 30-5-307.

Self-directed
Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify
state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above
the policies addressed in Item C-2-d. Select one:

○ The state does not make payment to relatives/legal guardians for furnishing waiver services.
○ The state makes payment to relatives/legal guardians under specific circumstances and only when the
relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom
payment may be made, and the services for which payment may be made. Specify the controls that are employed to
ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for
which payment may be made to relatives/legal guardians.
The State of Kansas does not prevent non-legally responsible relatives from providing PCS and ECS services. The non-responsible relative are subject to the same requirements as detailed in the service definitions and provider qualifications in Appendix C.

The State of Kansas defines legally responsible individuals as: 1) the parent (biological or adoptive) of a minor child; 2) a spouse of a waiver participant; 3) the legal guardian or activated DPOA of a waiver participant; 4) a foster parent.

KDADS allows legally responsible individuals to provide ECS under the following circumstances:

1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflicts of interest have been mitigated in accordance with K.S.A. 59-3068.
   a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
   b. It shall be the responsibility for the legal guardian to provide to the MCO and FMS provider a copy of the special or annual report in which the conflict of interest is disclosed and a copy of the judge’s order or approval determining that there is no conflict of interest for the guardian to be paid to provide HCBS supports for the participant.

2. If the court determines that all potential conflicts of interest have not been mitigated; or the legal guardian otherwise chooses to provide personal care services, the legal guardian shall select a designated representative, who is not a legally responsible individual for the participant, to develop the Person-Centered Service Plan and direct the participant’s HCBS services.

3. An A-DPOA, who is currently authorized to make financial, medical or other decisions on behalf of the participant, is not permitted to be a paid provider unless a designated representative is appointed to direct the individual’s care.

4. The MCO may grant an exception to the above listed criteria when one of the three circumstances is present:

1) The participant lives in a rural area, in which access to a provider is beyond a 50 mile radius from the participant’s residence and the relative or family member is the only provider available to meet the needs of the participant.

2) The participant lives alone and has a severe cognitive impairment, physical disability or intellectual disability

3) The participant has exhausted other support options offered by the MCO and absent ECS would be at significant risk of institutionalization.

The controls that are employed to ensure that payments are made only for services rendered include: MCO quarterly Quality Reviews to monitor that services that are provided are approved in the Person-Centered Service plan, monitoring of ECS services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.

Specify:

- Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:
Kansas provides for continuous, open enrollment of waiver service provider by way of an online provider enrollment portal (see https://www.kmap-state-ks.us/Public/provider.asp). The online portal also contains training materials and other useful information that prospective providers may access at their convenience, including a tip sheet and provider enrollment training video. The adequacy of MCO provider networks is monitored quarterly via standardized reports submitted through the KanCare Reporting System. HCBS waiver program management staff are maintained on a report distribution list and notified when a new report submission is received. Whenever the number of providers falls below the established network adequacy threshold, the HCBS program manager works with the MCO and KDHE to develop an action plan for achieving the required threshold.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of new licensed/certified provider applicants that met licensure/certification requirements, and other standards prior to furnishing services
N=Number of new licensed/certified waiver provider applicants that initially met licensure/certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
KanCare Managed Care Organization (MCO) reports and record reviews

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### Performance Measure:
Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards

- \(N\) = Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
- \(D\) = Number of enrolled licensed/certified waiver providers

### Data Source (Select one):
- Other
  If 'Other' is selected, specify:
  Managed Care Organization (MCO) reports and record reviews

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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 newly enrolled waiver providers that have met the initial waiver requirements prior to furnishing waiver services

\[ N = \text{Number of newly enrolled waiver providers} \]

\[ D = \text{Number of all newly enrolled waiver providers} \]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

Managed Care Organization (MCO) reports and record reviews

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  - Specify:
    - KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

### Frequency of data aggregation and analysis (check each that applies):

- **× Annually**
- **× Continuously and Ongoing**
- **Other**
  - Specify:

### Performance Measure:
Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements

\[
N = \text{Number enrolled non-licensed/non-certified providers} \\
D = \text{Number of enrolled non-licensed/non-certified providers}
\]

### 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):

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

| × Continuously and Ongoing |
| Other Specify: |

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 \( N = \text{Number of providers that meet training requirements} \)
\( D = \text{Number of active providers} \)

**Data Source** (Select one):

**Other**
If ‘Other’ is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

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**Data Aggregation and Analysis:**
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 team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

   State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

× Continuously and Ongoing

Other
Specify:

[Box for additional information]
c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (select one).

- Not applicable - The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (check each that applies)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.
Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Attachment #2 for the BI and Statewide Transition Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):

- Registered nurse, licensed to practice in the state
- Licensed practical or vocational nurse, acting within the scope of practice under state law
- Licensed physician (M.D. or D.O)
Case Manager (qualifications specified in Appendix C-1/C-3)
Case Manager (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Social Worker
Specify qualifications:

Other
Specify the individuals and their qualifications:

Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community Based Services (HCBS) services as one part of the comprehensive KanCare program. The MCOs are responsible for development of the Person-Centered Service Plan (Service Plan) in accordance with KDADS’ Person-centered Service Plan policy. The MCO or their designee will use their staff to provide that service.

Regarding Aetna: (Clinical) Service Coordinator positions require a registered nurse (RN) or a licensed, master’s level behavioral health professional (e.g. LMSW, 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 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.

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:
c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

MCOs and providers follow the processes outlined in the KDADS’ Person-Centered Service Plan policy to provide the individual with the maximum amount of opportunity to direct and be actively engaged in the person-centered planning process.

Each participant found eligible for BI waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that are available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant's chosen provider.

The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
The Person-Centered Service Plan process and expectations are outlined in the KDADS’ Person-Centered Service Plan policy.

a) MCOs may use contracted entities to assist in the development and monitoring of the Person-Centered Service Plan (Service Plan), but has primary responsibility for Service Plan development and accountability to deliver all Medicaid covered services included in a participant’s Service Plan. The initial and annual Service Plans are developed during a face-to-face meeting with the participant, legal representative (if applicable), the MCO and selected representatives that the participant chooses to be involved. Date and time of the Service Plan meeting is coordinated based on the convenience of the participant and the participant’s representative, if applicable. The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The KDADS’ Person-Centered Service Plan policy outlines who the required participants are in the development of the Service Plan. MCOs, or their designee, are required to invite known HCBS providers for the individual to the Service Plan meeting unless otherwise specified by the individual. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting. If the participant has a court appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on the Service Plan.

The Service Plan is valid for 365 days from the date of the participant’s and/or legal representative’s signature unless there is a change in condition that requires an update to the Service Plan as detailed in the Person-Centered Service Plan policy.

b) All applicants for program services must undergo a functional eligibility assessment to determine functional eligibility for the BI waiver. The FEI is utilized to determine the level of care (LOC) eligibility for the BI waiver. The state’s functional eligibility contractor conducts an assessment of the individual within the timeframe specified in the contract, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant that will identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant will complete a Participant Interest Inventory (PII). The PII is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Service Plan meeting and will use the PII to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

c) Each participant found eligible for BI waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that are available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant’s chosen provider.

d) Through the various assessments and Service Plan related documents described in b) above, the participant’s goals, needs and preferences are at the forefront of developing their Service Plan.

e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS’ Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan.

f) The responsibilities for implementing and monitoring delivery of services as authorized in the Service Plan are detailed in the Person-Centered Service Plan policy and the HCBS Quality Review Policy.

g) The Person-Centered Service Plan is subject to update during the face-to-face meetings between the MCOs and the waiver participants. Service Plan reviews will take place to determine the appropriateness and adequacy of the services,
and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. In the event a change in need, circumstance or condition occurs, the MCO will conduct a needs assessment to re-evaluate the scope, duration and amount of HCBS services the individual needs to stay safely in the community. During the Person-Centered Service Plan meeting the MCO Care Coordinator shall educate the participant on the following: service options that will assist the participant in progress toward established goal; identify care gaps; assess the participant’s understanding of risks and consequences if the care gaps remain; verify that the participant demonstrates understanding of risks, strategies to mitigate risks, consequences, and shall make appropriate referrals to address risks; and additional community and social supports available to the participant. Once the participant has signed the Person-Centered Service Plan, the plan is sent to the applicable providers. The providers then sign the plan to agree that they are able and willing to provide the applicable service in the scope, duration and amount authorized in the Person-Centered Service Plan. The MCO monitors the delivery of the service plan, which includes a 12 month face-to-face visit with the participant to evaluate the appropriateness of the current Service Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument as well as the MCO's needs assessment which identify potential risk factors. The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers. The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met. The Participant Interest Inventory (PII), a document that is a part of the Service Plan, describes, in the participant's own words, how the participant would like their supports to be provided. This includes any interventions that are identified as necessary to mitigate risk to the participant's health safety and welfare (PII Risk Assessment & Intervention Plans).

Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the Person-Centered Service Plan policy.

A back-up plan for each individual is established during the needs assessment and Person-Centered Service Plan development. This and other information from the assessment and annual re-assessment are incorporated into a backup plan which is utilized to mitigate risk related to extraordinary circumstances. Backup plans are developed according to the unique needs such as physical limitations and circumstances, such as the availability of informal supports of each participant. Backup arrangements are added to Service Plans and identify key elements, including specific strategies and contact individuals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.
The State assures that each participant will be given free choice of all qualified providers of each service included in his/her written Person-Centered Service Plan. The MCO provides each eligible participant with a list of providers from which the participant can choose a service provider. The MCO assists the participant with accessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers for waiver services identified in their Person-Centered Service Plan.

Appendix D: Participant-Centered Planning and Service Delivery

**D-1: Service Plan Development (7 of 8)**

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

KDADS conducts quarterly reviews of the MCOs to insure that the performance measures outlined in the waiver application are met. As part of the review, the initial, annual and current Person-Centered Service Plan are reviewed to insure compliance with performance standards. KDADS reports to KDHE on the findings of the audits during the quarterly audit meetings.

**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (8 of 8)**

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

Service plans and related documentation will be maintained by the participant's chosen KanCare MCO, and will be retained at least as long as this requirement specifies.

**Appendix D: Participant-Centered Planning and Service Delivery**

**D-2: Service Plan Implementation and Monitoring**

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the
implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The MCOs are responsible for monitoring the implementation of the Person-Centered Service Plan and for ensuring the health and welfare of the participant with input from the BI Program Manager and KDADS Regional Field Staff. Service Plan implementation is assessed through the comprehensive statewide KanCare Quality Improvement Strategy (which includes all of the HCBS waiver performance measures). Kansas also monitors the Adverse Incident Reporting system and implements corrective action plans for remediation with the MCOs.

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether or not to self-direct their services;
- Services meet participant’s needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant’s health and safety are assured, to the extent possible; and
- Participants have access to Medicaid State Plan services when the participant's need for services has been assessed and determined medically necessary.

Individual monitoring by the MCOs is defined as:
- Face-to-face meetings will occur in accordance with the Person-Centered Service Plan policy.
- Face-to-face meetings between MCO and participant are required every six months to evaluate the participant's ongoing needs.
- Face-to-face meetings are expected if the participant has a significant change in needs, eligibility, or preferences that will modify the participant’s current Person-Centered Service Plan.
- Contact with the participant on a monthly basis is required if the participant’s health and welfare needs are at risk of significant decline or the participant is in imminent risk of death or institutionalization.

In addition, the Person-Centered Service Plan and choice are monitored by state quality review staff as a component of waiver assurance and minimum standards. Any issues in need of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation and reported to the BI Program Manager.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. The HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency are part of this strategy.

State staff request, approve, and ensure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:
Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

_The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants._

i. Sub-Assurances:

a. _Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means._

**Performance Measures**

_For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator._

_For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate._

**Performance Measure:**

_Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed_

**Data Source** (Select one):

Other

If ‘Other’ is selected, specify:

**Record reviews**

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Confidence Interval = 95%

### OtherSpecify:

KanCare Managed Care Organizations (MCOs)

### StratifiedDescribe Group:

Proportionate by MCO

### Continuously and Ongoing

### OtherSpecify:

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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

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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:
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KanCare Managed Care Organizations (MCOs)

Annually

Stratified Describe Group:
Proportionate by MCO

Continuously and Ongoing

Other Specify:

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Frequency of data aggregation and analysis (check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually
- Continuously and Ongoing

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures
For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver

N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver

D=Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):
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### Performance Measure:

Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan

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\begin{align*}
N &= \text{Number of waiver participants (or their representatives)} \\
D &= \text{Number of waiver participants whose service plans were reviewed}
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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):
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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

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**Performance Measure:**

Number and percent of person-centered service plans reviewed within required timeframes as specified in the approved waiver

N=Number and percent of person-centered service plans reviewed within required timeframes as specified in the approved waiver

D=Number of waiver participants whose person-centered service plans were reviewed
Data Source (Select one):
Other
If 'Other' is selected, specify:

**Record reviews**

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Frequency of data aggregation and analysis (check each that applies):

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- **Continuously and Ongoing**

Other

Specify:

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d. **Sub-assurance**: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who received services and supports as authorized in their person-centered service plans

- **N** = Number of waiver participants who received services and supports as authorized in their person-centered service plans
- **D** = Number of waiver participants whose person-centered service plans were reviewed

Data Source (Select one):

- **Other**
  - If 'Other' is selected, specify:

Record Reviews and Electronic Visit Verification (EVV) reports

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#### 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

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Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care $N=$Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care $D=$Number of waiver participants whose files are reviewed for the documentation
Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

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### Frequency of data aggregation and analysis (check each that applies):

- **Annually**
- **Continuously and Ongoing**

### Performance Measure:

**Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers**

\[
N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver service providers}
\]

\[
D = \text{Number of waiver participants whose files are reviewed for the documentation}
\]

**Data Source** (Select one):

- **Other**
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**Record reviews**

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**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

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| Sub-State Entity | ✗ Quarterly | ✗ Representative Sample  
Confidence Interval = 95% |
| ✗ Other  
Specify: KanCare Managed Care Organizations | ✗ Annually | ✗ Stratified  
Describe Group: Proportionate by MCO |
| ✗ Other  
Specify: | ✗ Continuously and Ongoing | Other  
Specify: |

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- Continuously and Ongoing

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services. 

\[
N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver services.}
\]

\[
D = \text{Number of waiver participants whose files are reviewed for the documentation.}
\]

Data Source (Select one):
- Other
  If ‘Other’ is selected, specify:

Record reviews

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**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.**
Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program is operationalized, staff of the three manage care health plans will engage with state staff to ensure strong understanding of Kansas’ HCBS waiver programs and the quality measures associated with each waiver program. Over time, the role of the MCOs in collecting and reporting data regarding the waiver performance measures will evolve, with increasing responsibility once the MCOs fully understand the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

   State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

   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)

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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) All participants of BI waiver services have the opportunity to choose the KanCare managed care organization that will support them in overall service access and care management. The opportunity for participant direction (self-direction) of Personal Services and Enhanced Care Services is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100). This opportunity includes specific responsibilities required of the participant, including:

- Recruitment and selection of Personal Care Attendants (PCAs), back-up PCAs and ECS workers
- Financial Management Service (FMS) providers;
- Assignment of service provider hours within the limits of the authorized services;
- Complete an agreement with an enrolled Financial Management Services (FMS) provider;
- Referral of providers to the participant’s chosen FMS provider;
- Provider orientation and training;
- Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
- Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
- Other monitoring of services; and
- Dismissal of attendants, if necessary.

b) Participants are provided with information about self direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant’s Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant’s Person-Centered Service Plan. The MCO supports the participant who selects self direction of services by monitoring services to ensure that they are provided by Personal Care Service workers and Enhanced Care Service workers in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) FMS Provider Responsibilities

The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider.

FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

- Verification and processing of time worked and the provision of quality assurance;
- Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers’ compensation insurance requirements; making tax payments to appropriate tax authorities;
- Performance of fiscal accounting and expenditure reporting to the participant or participant’s representative and the state, as required.
- Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant’s representative in managing and directing services;
2. Assistance to the participant or participant’s representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. Select one:

- **Participant: Employer Authority.** As specified in Appendix E-2, Item a, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

- **Participant: Budget Authority.** As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

- The participant direction opportunities are available to persons in the following other living arrangements. Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

- Waiver is designed to support only individuals who want to direct their services.

- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction option is available for Personal Care Services and Enhanced Care Services. Participant-direction is not offered for the following services:

- Occupational Therapy
- Physical Therapy
- Cognitive Rehabilitation/Therapy
- Behavior Therapy
- Speech/Language Therapy
- Home-Delivered Meals Service
- Transition Living Skills
- Financial Management Services
- Assistive Services
- Medication Reminder Services
- Personal Emergency Response System

Self-direction is not an option when the participant/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be referred by the MCO to KDADS for concurrence of action and is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.
a) Participants are informed that, when choosing participant direction (self direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self direct services:

• the 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 personal care attendants;
• the ability of the participant to choose not to self direct services at any time; and
• other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency-directed services.

b) The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chosen this option and identified an enrolled provider. This information is also available from the BI Program Manager, KDADS Regional Field Staff, and is also available through waiver policies and procedures manual.

c) Information regarding self-directed services is initially provided by the MCO during the Person-Centered Service Plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's Person-Centered Service Plan. This information is reviewed at least annually with the member. The option to end self direction can be discussed, and the decision to choose agency-directed services can be made at any time.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (select one):

- The state does not provide for the direction of waiver services by a representative.
- The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (check each that applies):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that non-legal representatives' has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

To ensure that non-legal representatives function in the best interests of the participant, additional safeguards are in place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the participant's case file, certain situations arise, particularly when the participant's health and welfare needs are not being met. In addition, post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS 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.

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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Care Services</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Personal Care</td>
<td>☒</td>
<td></td>
</tr>
</tbody>
</table>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one:

- Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. Check each that applies:

- Governmental entities
  - ☒ Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)
i. ** Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3
  - The waiver service entitled:
    - Financial Management Services
- FMS are provided as an administrative activity.

**Provide the following information**

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled FMS providers will furnish Financial Management Services using the Employer Authority model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites. Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers will be reimbursed a monthly fee per participant through the electronic MMIS system (MMIS). The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies)*:

- Assist participant in verifying support worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

**Other**

*Specify:*
Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant’s participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
The state verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment [KDHE]). Requirements include agreements between the FMS provider and the participant, Direct Support Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Support Worker time worked and payroll distribution. Additionally, the state will assure FMS provider development and implementation of procedures including, but not limited to, procedures to maintain background checks; maintain internal quality assurance programs to monitor participant and Direct Support Worker satisfaction; maintain a grievance process for Direct Support Workers; and offer choice of Information and Assistance services.

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit KDHE or KDADS, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59).

(b) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by KDADS. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change. KDHE through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities.

(c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency.

(d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members, and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

In general, contracted managed care entities are responsible for ensuring the FMS entity is in compliance with federal/state policies and procedures. KDHE through its operating agency KDADS, establish a provider agreement with the FMS provider and conduct monitoring activities of the FMS entity in accordance with the terms of the agreement and policies and procedures. In accordance with established agreements, KDADS requires GAP audits initially and every 3 years. In addition, KDADS reviews the FMS financial report and determine financial integrity annually.

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):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Services</td>
<td>×</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>×</td>
</tr>
<tr>
<td>Behavior Therapy</td>
<td>×</td>
</tr>
<tr>
<td>Enhanced Care Services</td>
<td>×</td>
</tr>
<tr>
<td>Personal Emergency Response System and Installation</td>
<td></td>
</tr>
<tr>
<td>Financial Management Services</td>
<td></td>
</tr>
<tr>
<td>Medication Reminder Services</td>
<td></td>
</tr>
<tr>
<td>Transitional Living Skills</td>
<td></td>
</tr>
<tr>
<td>Home-Delivered Meals Service</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
<td></td>
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<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td></td>
</tr>
</tbody>
</table>

× Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.
Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent advocacy is available to participants who direct their services through the Disability Rights Center of Kansas (DRC), the state's Protection and Advocacy organization. DRC is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC operates eight federally authorized and funded protection and advocacy programs in Kansas, including a program specifically for persons with BI. Participants are referred directly to DRC from various sources, including KDADS. These organizations do not provide direct services either through the waiver or through the Medicaid State Plan.

Independent advocacy is also available through the Brain Injury Association of Kansas and Greater Kansas City (BIAKS). The mission of BIAKS, an affiliate of the national Brain Injury Association of America, is to be the voice of brain injury in the state in a way that contributes to the improvement of the quality of life for survivors and family members. BIAKS provides timely information, resources, and training to survivors and family members through various means including support groups, seminars, and individual contact. BIAKS acts as a source of disinterested assistance to participants and family members in that it provides no direct waiver or State plan services to participants or assessment, monitoring, fiscal, or service oversight functions that have a direct impact on the participant. Participants access support through direct contact with BIAKS. A link to the BIAKS web site is available on the KDADS web site.

Appendix E: Participant Direction of Services
E-1: Overview (11 of 13)

1. 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. At any time, 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) provider.
- Maintain continuous coverage for authorized Personal Care Services and/or ECS
- Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the participant, to allow for the coordination of service provision.

The duties of the participant's KanCare MCO are to:

- Explore other service options and complete a new Participant Choice form with the participant; and
- Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources
- Work with the participant to maintain continuous coverage as outlined and authorized in the participant's Service Plan.
- The MCO, though their care management and monitoring activities, works with the participant's self-directed provider to assure participant health and welfare during the transition period.
- Ensure open communication with both the participant and the self-directed provider, monitor the services provided, and gather continual input from the participant as to satisfaction with their services.

Appendix E: Participant Direction of Services
E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.
The 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 the following conditions will be compromised if participant-direction continues:

- The health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS, and all training methods have been exhausted;
- The PCS is not providing the services as outlined on the PCS Skilled worksheet, and the situation cannot be remedied;
- The participant is at risk for fraud, abuse, neglect and exploitation;
- The participant is falsifying records resulting in claims for services not rendered;
- 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 agency-directed services as an alternative. If the participant chooses the alternative agency-directed services, the MCO will assess the participant's needs and coordinate services according to the individual's health and safety needs.

**Appendix E: Participant Direction of Services**

**E-1: Overview (13 of 13)**

**n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Employer Authority Only</th>
<th>Budget Authority Only or Budget Authority in Combination with Employer Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>267</td>
<td></td>
</tr>
</tbody>
</table>

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant Direction (1 of 6)**

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. Select one or both:

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:
Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Select one or more decision making authorities that participants exercise:

- Recruit staff
- Refer staff to agency for hiring (co-employer)
- Select staff from worker registry
- Hire staff common law employer
- Verify staff qualifications
- Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The direct service worker (provider) will assume the cost of criminal history and/or background investigations conducted by the financial management service provider as an administrative function.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

- It does not vary from Appendix C-2-a.

- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to state limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services
E-2: Opportunities for Participant-Direction (2 of 6)
b. Participant - Budget Authority  Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Select one or more:

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the state's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.
Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.
Request for Fair Hearing Regarding a Functional Eligibility Determination:

Kansas has contracted with independent assessors to conduct level of care determinations (functional eligibility). Decisions made by the independent assessors are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors with their decision on the LOC determination/redetermination.

Applicants/beneficiaries may file only a fair hearing for an adverse decision by MCO:

KanCare Managed Care Organizations (MCOs) are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member.

Each participant is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. Participant grievance processes and Fair Hearing processes can also be found at the KanCare website.

KanCare participants have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 calendar days of receipt, and written response to the grievance will be given to the participant within 30 calendar days (except in cases where it is in the best interest of the member that the resolution timeframe be extended). If the MCO fails to send a grievance notice within the required timeframe, the participant is deemed to have exhausted the MCO’s appeal process, and the participant may initiate a State Fair Hearing.

An appeal can only occur under the following circumstances:
• If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
• Members will receive a Notice of Action in the mail if an Action has occurred.
• An Appeal is a request for a review of any of the above actions.
• To file an Appeal: Members or (a friend, an attorney, or anyone else on the member’s behalf can file an appeal).
• An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
• An appeal must be filed within 60 days calendar days plus 3 calendar days after the participant has received a Notice of Action.
• The appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant’s appeal will be resolve in 45 calendar days.

Fair Hearings

A member may request a Fair Hearing upon receiving a Notice of Action.

A Fair Hearing is a formal meeting where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all the facts and then hears motions, conduct hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge.

If the participant is not satisfied with the decision made on the appeal, the participant or their representative may ask for a fair hearing. The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision.

The request be submitted in writing and mailed or faxed to:
Office of Administrative Hearings 1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

Participants have the right to benefits continuation of previously authorized services while a hearing is pending and can request such benefits as a part of their fair hearing request. All three MCOs will advise participants of their right to a State Fair Hearing. Participants have to finish their appeal with the MCO before requesting a State Fair hearing.

For all KanCare MCOs:
In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs’ member web site. In addition, every notice
of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

The State requires that all MCOs define an “action” pursuant to the KanCare contract and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event their Medicaid application is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

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.
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.

The MCOs as the fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The MCO staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are educated that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the BI Waiver Program Manager.

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:


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).

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).
The state provides for the reporting and investigation of the following major and serious incidents.

Definitions of Kansas Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 39, Article 14 for adults:

K.S.A. 39-1430. Abuse, Neglect or Exploitation of certain adults:

K.S.A. 39-1430(b):
Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a waiver participant, including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult; 4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician’s orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5) a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6) Fiduciary Abuse; or 7) omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

K.S.A. 39-1430(c):
Neglect: The failure or omission by one’s self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

K.S.A. 39-1430(d):
Exploitation: Misappropriation of an adult’s property or intentionally taking unfair advantage of an adult’s physical or financial resources for another individual’s personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

K.S.A. 39-1430(e):
Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person’s trust or benefit.

Department for Children and Families (DCF) reportable events as described in Kansas Statute:

c. 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;

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 Chapter 38, Article 22 for children:

- **Neglect - K.S.A. 38-2202(t):** Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child’s parents or other custodian. Neglect may include, but shall not be limited to:
  - (1) Failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child;
  - (2) failure to provide adequate supervision of a child or to remove a child from a situation which requires judgment or actions beyond the child’s level of maturity, physical condition or mental abilities and that results in bodily injury or a likelihood of harm to the child; or
  - (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent; however, this exception shall not preclude a court from entering an order pursuant to K.S.A. 2018 Supp. 38-2217(a)(2), and amendments thereto.

- **Physical, Mental or Emotional Abuse - K.S.A. 38-2202(y):** The infliction of physical, mental or emotional harm or the causing of a deterioration of a child and may include, but shall not be limited to, maltreatment or exploiting a child to the extent that the child’s health or emotional well-being is endangered

- **Sexual Abuse - K.S.A. 38-2202(ff):** Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child or another person. Sexual abuse shall include, but is not limited to, allowing, permitting or encouraging a child to:
  - (1) Be photographed, filmed or depicted in pornographic material; or
  - (2) be subjected to aggravated human trafficking, as defined in K.S.A. 2018 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another, or be subjected to an act which would constitute conduct proscribed by article 55 of chapter 21 of the Kansas Statutes Annotated or K.S.A. 2018 Supp. 21-6419 or 21-6422, and amendments thereto.

- **Abandonment - K.S.A. 38-2202 (a):** To forsake, desert or, without making appropriate provision for the substitute care, cease providing care for the child.

- **Fiduciary Abuse - K.S.A. 39-1430(e):** A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person’s trust or benefit.

All DCF reportable events including Abuse, Neglect, Exploitation, and Fiduciary Abuse are required to be reported to the Kansas Department for Children and Families and once a determination has been made by DCF, the event must be entered into the Adverse Incident Reporting (AIR) system by KDADS if the event has not yet been entered by DCF staff in accordance with KDADS HCBS Adverse Incident Monitoring Standard Operating Procedure (SOP).

Reporting KDADS defined adverse incident requirements:

Other adverse incidents to be reported by KDADS staff into AIRS include, Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusions, and Restrictive interventions. See KDADS HCBS Adverse Incident Reporting

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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 programs, 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 government 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 Monitoring SOP. These include, in addition to suspected incidents of Abuse, Neglect, Exploitation or Fiduciary Abuse: Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Restraint, Seclusion, E/R visit, Hospitalization, Misuse of Medications.
Natural Disaster, Serious Injury, Suicide, Suicide Attempt. See KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 for definitions of KDADS reportable adverse incidents. Also, the reporter can select as many adverse incidents as may apply per that particular situation. Anyone who suspects a child or adult is experiencing any of the above types of DCF reportable events or KDADS adverse incidents may also report it through the DCF hotline.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

- The participant’s chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development. Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant’s Person-Centered Service Plan. The information provided by the MCOs is consistent with the state’s Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.
• The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.

The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of 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.

- 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. DCF assigns the response time, ranging from same day to 7 days, depending on whether abuse is suspected and other characteristics. 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.

KDADS first reviews the adverse incident report information to determine if there is any indication of criminal activity or ANE that has not been reported to appropriate agencies. If the incident has not already been reported to DCF, KDADS reports it to DCF. KDADS next determines if the incident is screened in, screened-out, or requires follow-up. For all screened in adverse incidents, KDADS staff assign a severity level. MCOs take steps for follow-up with providers/members, and resolve the incident or implement remediation steps. KDADS tracks and approves MCO investigation and resolution steps. KDADS staff review MCO follow-up and resolution details. KDADS also determines if the incident should require a corrective action plan (CAP) outlining the deficiencies and necessary steps to resolve. KDADS monitors MCO CAP remediation efforts and required completion dates to ensure timely resolution.

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
a. **Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- The state does not permit or prohibits the use of restraints

  Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraints. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of restraint and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

A finding of screened out given to reports, submitted to DCF, that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

All screened out (unsubstantiated) and screened-in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

All DCF determinations received by KDADS (screened in and screened out) are considered adverse incidents by KDADS and are entered into the AIR system for remediation and follow-up. The DCF determination informs KDADS’ on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

- How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1) Air performance data on each health and welfare performance measure as identified in each HCBS waiver
2) Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.)
3) Trend analysis on each adverse incident
4) Remediation efforts by health and welfare performance measure as identified in each HCBS waiver
5) Remediation efforts by each adverse incident

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff
will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

- The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:
- Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents
- Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident
- Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

1. 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).

2. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restrictive interventions. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of restrictive interventions and ensuring that all applicable state requirements are followed:

All adverse incidents (including all unauthorized use of restrictive interventions) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

A finding of screened out is given to reports that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

All screened out (unsubstantiated) and screened in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

All DCF determinations (screened out, substantiated and unsubstantiated) received by KDADS are considered adverse incidents by KDADS and are entered into the AIR system for remediation and follow-up. The DCF determination informs KDADS’ on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

- 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

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to...
WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.

☐ The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
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.

A finding of screened out is given to reports that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

All screened out (unsubstantiated) and screened in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

All DCF determinations (screened out, substantiated and unsubstantiated) received by KDADS are considered adverse incidents by KDADS and are entered into the AIR system for remediation and follow-up. The DCF determination informs KDADS’ on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened out by KDADS and closed in the AIR system.

• 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,
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.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.
a. Applicability. Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

   i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

   ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. Select one:

   - Not applicable. (do not complete the remaining items)
   - Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (complete the remaining items)

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. Select one of the following:

   - Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies). Complete the following three items:

     (a) Specify state agency (or agencies) to which errors are reported:
(b) Specify the types of medication errors that providers are required to record:

(c) Specify the types of medication errors that providers must report to the state:

○ Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.


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 instances of 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 where the MCO and KDADS confirm the identify of preventable causes $D=$ Total number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:

Record reviews

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Data Aggregation and Analysis:
Responsible Party for data aggregation and analysis *(check each that applies):*  

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KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency

Performance Measure:
Number and percent of preventable unexpected deaths that resulted in a State-issued corrective action plan (CAP)  
\[ N = \text{Number of preventable unexpected deaths} \]
\[ D = \text{Number of preventable unexpected deaths} \]

Data Source *(Select one):*  
Other  
If 'Other' is selected, specify:  
Record reviews

Responsible Party for data collection/generation *(check each that applies):*  

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Confidence Interval =
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KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency

Other Specify:
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**

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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:
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b. **Sub-assurance:** The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

## Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

Number and percent of reported adverse incidents for which review / investigation followed the appropriate policies and procedures

N = Number of reported adverse incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver

D = Number of reported adverse incidents

### Data Source (Select one):

- **Other**

  If ‘Other’ is selected, specify:

  **Critical Incident Management System**

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### Performance Measure:

Number and percent of reported adverse incidents year to date (YTD) that were initiated and reviewed within required timeframes

\[ N = \text{Number of reported adverse incidents year to date (YTD)} \]

\[ D = \text{Number of reported adverse incidents year to date (YTD)} \]

\[ \text{Performance Measure:} \]

\[ \text{Number and percent of reported adverse incidents year to date (YTD) that were initiated and reviewed within required timeframes} \]

\[ N = \text{Number of reported adverse incidents year to date (YTD)} \]

\[ D = \text{Number of reported adverse incidents year to date (YTD)} \]

\[ \text{Data Source (Select one):} \]

**Other**

If ‘Other’ is selected, specify:

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Frequency of data aggregation and analysis (check each that applies):

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Other
Specify:

Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unauthorized uses of restraint applications and seclusion that were appropriately reported N=Number and percent of unauthorized uses of restraint applications and seclusion that were appropriately reported D=Number and percent of unauthorized uses of restraint applications and seclusion.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record Reviews

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Performance Measure:
Number and percent of restraint applications and seclusions that followed procedures as specified in the approved waiver

N = Number of restraint applications and seclusions that followed procedures as specified in the approved waiver

D = Number of restraint applications and seclusions

Data Source (Select one):
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If 'Other' is selected, specify:
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- **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

\[ N = \text{Number of HCBS participants who received physical exams in accordance with State policies} \]

\[ D = \text{Number of HCBS participants whose service plans were reviewed} \]

**Data Source (Select one):**

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**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

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ii. If applicable, in the text below, provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Collaboration between the KDADS Field Staff and DCF-APS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with TA waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant’s knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

During quality review activities, in the event KDADS staff discovers any areas of vulnerability, the staff will issue findings and request remediation or corrective action depending upon the severity of the finding. In the event that protection from harm is necessary, KDADS staff will work with the managed care coordinator and providers to identify an alternative setting and immediately remove the individual from a dangerous environment. Any provider under investigation for ANE will be required to be suspended from providing services to the participant until the allegation can be substantiated and a corrective action leading to possible termination is necessary.

KDADS and Managed Care health plans are responsible for ensuring appropriate training and policies and procedures are put in place as part of the corrective action plan in order to ensure settings are secured, to the fullest extent possible, so that future occurrences are minimized.

DCF’s Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a database of all critical incidents/events and makes available the contents of the database to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Adult Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

During quality review activities, in the event KDADS staff discovers any areas of vulnerability, the staff will issue findings and request remediation or corrective action depending upon the severity of the finding. In the event, protection from harm is necessary KDADS staff will work with the managed care coordinator and providers to identify an alternative setting and immediately remove the individual from a dangerous. Any provider under investigation for ANE will be required to be suspended from providing services to the individual until the allegation can be substantiated and a corrective action leading to possible termination is necessary.

KDADS and managed care health plan is responsible for ensuring appropriate training and policies and procedures are put in place as part of the corrective action plan in order to ensure settings are secured to the extent possible so that future occurrences are minimized.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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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.
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

- Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the state’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.
Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.
The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful participant feedback on the HCBS program. KDADS reviews a statistically significant sample of participants for the BI waiver population (KS.4164) and the other affected waiver populations under the Quality Improvement Strategy each quarter. These include the Frail Elderly (KS.0303), I/DD (KS.0224), Physical Disability (KS.304), Serious Emotional Disturbance (KS.0320), Autism (KS.0476) and Technology Assisted (KS.4165) waiver populations. The sampling will be done for each waiver individually as will all of the data aggregation, analysis and reporting.

The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE’s Long-Term Care Committee, and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor’s systems as well as the Managed Care Organizations’ systems. On a routine basis, KDADS’ Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency’s critical incident management system. KDADS worked with Adult Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS’ Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff and other management staff each quarter. 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. Any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s). In addition, AIR reports are aggregated and presented to the MCOs monthly to inform remediation strategies.

### ii. System Improvement Activities
b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain participant feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with DXC to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and DXC staff to generate recommended systems changes, which are then monitored and analyzed by the fiscal agent and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.
Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state’s Quality Improvement Strategy:
KDHE and KDADs meet monthly (Long Term Care meeting), to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (Select one):
   - No
   - Yes (Complete item H.2b)

b. Specify the type of survey tool the state uses:
   - HCBS CAHPS Survey :
   - NCI Survey :
   - NCI AD Survey :
   - Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Coordination of Program Integrity Efforts.
The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas’ Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General’s Office. At a minimum, the CONTRACTOR shall:

a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
c. Report 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 participant of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and
management of the program integrity efforts required under this contract. This person shall be designated as the Program
Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing
data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR
is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
(1) Oversight of the program integrity function under this contract;
(2) Liaison with the State in all matters regarding program integrity;
(3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
(4) Liaison with Kansas’ MFCU;
(5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

The State makes payment to the MCO based on the eligibility category assigned by the eligibility system, KEES. The
eligibility file is loaded on a nightly basis to the MMIS. Any changes that occur to the participant’s eligibility are made in
KEES, sent to the MMIS, and updated nightly. Capitation payments are made to the MCOs’ retrospectively. The
reconciliation process in the MMIS with the 834 will catch the capitation error and recoup against the MCO payment.

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the
beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should
include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain
to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.
Only Native American populations can opt out of managed care.

These claims could be pulled into a SURS audit. Audits could be conducted by SURS or by a federal entity such as PERM.
The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal
agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to
CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider
is flagged as an outlier or for questionable billing practices.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the
waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization
Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were
concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes
requesting provider documentation for services rendered.

Appendix I: 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

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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

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b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.
For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS throughout the five year renewal cycle. N= Number of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS. D=Total number of capitation (payment) rates.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Rate-setting documentation

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Application for 1915(c) HCBS Waiver: Draft KS.012.06.10 - Jan 01, 2024
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state established a KanCare Interagency Coordination and Contract Monitoring (KICCM) to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, which engages program management, contract management and financial management staff of both KDHE and KDADS.

### Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive quality assurance strategy which is regularly reviewed and adjusted.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy. KDADS HCBS Program Managers participate in monthly long-term care (LTC) meetings with KDHE, and work with the KDADS Quality team on quarterly monitoring developing remediation for LOC Assessors and MCOs. Program Managers send out template for LOC assessors or MCO’s to complete for Performance Measures that fall below 87% compliance. The assessor agency or MCO must complete the template with their remediation plan and return to the HCBS Director. Program Manager’s review and accept or deny the plan and track progress on the remediation plan meeting compliance and continuously monitor for needed adjustments to meet remediation targets.

### ii. Remediation Data Aggregation

**Remediation-related Data Aggregation and Analysis (including trend identification)**

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### c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

### Appendix I: Financial Accountability

#### I-2: Rates, Billing and Claims (1 of 3)

- **a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment
rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified to and approved by CMS.

Capitation rates are based on actuarial analysis of historical data for all BI 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.

FFS claims would be paid with FFS rates per the fee schedule. HCBS FFS/Managed Care Floor Rates are made available via the Kansas Medical Assistance Program (KMAP) Website. The State Operating Agency in coordination with the Medicaid Agency determines the rate.

The State ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt out from Managed Care. In the event, there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available. FFS rates can be found via State Bulletins via the State’s KMAP website.

The State does not currently have a set timeframe for regular reviews of the FFS rates for BI services. However, there are periodic checks of the rates and utilization for each of the services on the waiver. The State has leveraged, and will continue to leverage, multiple sources to assist in researching the adequacy of our rates. This would include strategies such as engaging with a consulting group to provide a rate study of surrounding states to benchmark where Kansas rates rank. The State also periodically requests that the MCOs review rates for similar services in other markets that they serve. Additionally, the State has open lines of communication with various provider groups, and welcomes research performed by such groups as another data point. The goal of these studies is to ensure that the rates for waiver services are sufficient to encourage providers to continue serving the waiver population, thus maintaining network adequacy. The agency has discretion to set and adjust the rates as they deem necessary; if the agency determines that a rate change is necessary, they would write a policy to change the fee schedule accordingly. Changing rates does not require legislative authority; however, since the legislature is the only body that can appropriate funds, the agency would need to request funding from the legislature to increase its budget to account for the increased spend associated with a rate change.

FFS rates can be found via State Bulletins via the State’s KMAP website. Below is the link to the FFS rate bulletin as of July 1, 2018.


The State understands that this section must be amended with a description of a public comment process compliant with the guidance as laid out in 42 CFR 447.205 if anyone enrolled in the waiver were to opt out of managed care.

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.

Claims are received via electronic or paper media. Electronic claims are separated out between MCO and FFS based on the Beneficiary ID and the first date of service on the claim compared with the eligibility file. The claims, where assignment to an MCO is found for that date of service, are sent to the MCO for processing. Claims without an MCO assignments are processed FFS.

Paper claims are sent back to the provider if it can be determined the beneficiary is assigned to an MCO. Otherwise, the claims are processed through the MMIS and deny if the beneficiary is assigned to an MCO or process through the FFS claims engine if not assigned.

The claims are processed through the claims engine based on the beneficiary’s benefit plan HCBS/Head Injury (HCHI). This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

For a Medicaid recipient (for example a Native American) who has chosen to not enroll in the MCO the claim would pay. The member’s assignment would be FFS.

The FFS pay schedule is located on the KMAP website. Providers are able to search codes and see the rate assigned to the code. If and when the fee schedule is updated in the MMIS, providers are notified through the KMAP bulletin process. Claims are paid on the date of service specific to the fee schedule in place.

Claims submitted to the fiscal agent process through the MMIS claim engine. Claims are edited for a Medicaid recipient’s eligibility, assignment, Person-Centered Service Plan, provider type/specialty, prior authorization (if required), procedure and claim coding which cycle through the CMS approved state specific CCI edits. Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.) Direct Support Workers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation.

In EVV, each Direct Support Worker who has passed the KDADS’ Background Check has a Worker ID associated with a provider agency. Information in EVV explains the list of services the Direct Support Worker is noted as providing. Any deviation from that service list is noted in an exception on the claim. In order to bill for agency-directed PCS, a provider must be enrolled in KMAP. To enroll in KMAP the agency must submit their Home Health Agency license, which is required for agency-directed PCS. The MCOs verify provider qualifications annually for all HCBS providers.

ii) MCOs submit authorizations to AuthentiCare for services that have been determined necessary by the participant’s functional assessment. Authorizations included the timeline of service delivery, the service to be delivered and the number of units that were determined by the participant’s assessment. All claims for service created by the Check-In and Checkout are subject to the timeline, the service, and the number of service units on the claim. Any claims that do not meet the service, the timeline and/or the number of units for which the participant was assessed are marked with a Critical Exception which will render the provider unable to confirm the claim for export.

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 participant’s Person-Centered Service Plan detailing authorized services. MCOs submit authorizations to the EVV system for services that have been determined necessary by the participant’s functional assessment and MCOs needs assessment. Authorizations included the timeline of service delivery, the service to be delivered and the number of units that were determined by the participant’s assessment. All claims for service created by the Check-In and Checkout are subject to the timeline, the service, and the number of service units on the claim. Any claims that do not meet the service, the timeline and/or the number of units for which the participant was assessed are marked with a Critical Exception which will render the provider unable to confirm the claim for export.

The following process is in place for all HCBS claims that are subject to the EVV system including those paid on a FFS basis.
1. Claims created in the EVV system are subject to provider review and confirmation.
2. Claims can be confirmed if Critical Exceptions do not exist.
3. Confirmed claims are exported to Payers in an 837 claims file.
4. The 837 claims file exports at a set time early the next morning following confirmation.

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.

The Medicaid Management Information System (MMIS) verifies an individual is eligible for Medicaid payment on the date of service. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS.

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

**Appendix I: Financial Accountability**

**I-3: Payment (1 of 7)**

**a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.

FFS providers have the option to be paid via a check or through EFT. Payment is made based on the provider's preference.

All other claims paid outside of the MMIS system are paid to the MCOs through a per member per month capitated payment. The claim is received and processed through the MMIS Claims Engine. The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.

In the event a FFS participant chose to Self-Direct their services, those services would be provided by an FMS provider that is enrolled with the Medicaid Program that would act as a limited fiscal agent between the state and the participant/employer.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The state does not make supplemental or enhanced payments for waiver services.
- Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:
Appendix I: Financial Accountability
I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability
I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

- No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Appendix I: Financial Accountability
I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments.
to a governmental agency.

- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- This waiver is a part of a concurrent §1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.
If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency
- × Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures is 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
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:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- No. The state does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible
Coinsurance
Co-Payment
Other charge
Specify:

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability
I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:
Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

<table>
<thead>
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<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24878.37</td>
<td>18972.00</td>
<td>43850.37</td>
<td>121906.00</td>
<td>18941.00</td>
<td>140847.00</td>
<td>96996.63</td>
</tr>
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<td>24878.37</td>
<td>18972.00</td>
<td>43850.37</td>
<td>121906.00</td>
<td>18941.00</td>
<td>140847.00</td>
<td>96996.63</td>
</tr>
<tr>
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<td>18972.00</td>
<td>43850.37</td>
<td>121906.00</td>
<td>18941.00</td>
<td>140847.00</td>
<td>96996.63</td>
</tr>
<tr>
<td>4</td>
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<td>18972.00</td>
<td>43850.37</td>
<td>121906.00</td>
<td>18941.00</td>
<td>140847.00</td>
<td>96996.63</td>
</tr>
<tr>
<td>5</td>
<td>24878.37</td>
<td>18972.00</td>
<td>43850.37</td>
<td>121906.00</td>
<td>18941.00</td>
<td>140847.00</td>
<td>96996.63</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>723</td>
<td>Hospital: 723</td>
</tr>
<tr>
<td>Year 2</td>
<td>723</td>
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<td>Year 3</td>
<td>723</td>
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<td>Year 4</td>
<td>723</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>723</td>
<td></td>
</tr>
</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.
The average length of stay (ALOS) was estimated through the following methodology: the total days of waiver enrollment for SFY2015 through SFY2017 were added together (562,972) and divided by three to obtain the average number, 187,657.333. The average number of days of waiver coverage was then divided by 597 (the three-year average of the unduplicated participants during SFY2015 through SFY2017). The estimated average length of stay is 314.333 or 314 days.

The state uses historical data sources for the ALOS calculation, not the 372 historical reports methodology. The data used for the waiver length of stay estimation is derived from the Kansas Medicaid Management Information System (MMIS).

The data for the 372 report is pulled 18 months after the end of the reporting period. For the Appendix J estimates, the state repulled the SFY2015 through SFY2017 MMIS data during the waiver renewal process to capture the most accurate waiver program changes.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D is estimated by utilizing encounter data from the Kansas Medicaid Management Information System and reflects MCO payments to the providers, using a three-year (SFY2015 through SFY2017) base average of $23,313. The three-year average was trended/adjusted to account for HCBS rate increases that occurred during SFY2018 and SFY2019.

This is an estimate of MCO encounters and is not reflective of the State’s capitation payments made to the MCO.

The state reports Factor D on the 372 report based on the managed care instructions received from CMS on 1/26/2015. The derivation of Factor D reported in the waiver renewal is based upon the Appendix J reporting methodology that was approved by CMS on 5/24/2016.

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 (SFY2015 through SFY2017) of waiver capitation costs less a three-year average (SFY2015 through SFY2017) of MCO encounter payment costs. The waiver capitation costs and MCO encounter payment costs are derived from the Kansas Medicaid Management Information System.

The state reports Factor D’ on the 372 report based on the managed care instructions received from CMS on 1/26/2015. The derivation of Factor D’ reported in the waiver renewal is based upon the Appendix J reporting methodology that was approved by CMS on 5/24/2016.

Factor D’ estimates do not include the cost of prescribed drugs that are furnished to Medicare/Medicaid dual eligible under the provisions of Medicare Part D.

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 Medicaid Management Information System and reflects the MCO encounter payments to providers for the institutional alternative, using a three-year average (SFY2015 through SFY2017).

The State used MCO encounters claims data from the Kansas Medicaid Management Information System as the base data in the derivation of Factors G and G' to most accurately represent the cost associated with those served in the institutional equivalent.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is estimated by utilizing data from the Kansas MMIS system and reflects the MCO encounter payments to providers for all services other than those included in Factor G, using a three-year average (SFY2015 through SFY2017).

The State used MCO encounters claims data from the Kansas Medicaid Management Information System as the base data in the derivation of Factors G and G' to most accurately represent the cost associated with those served in the institutional equivalent.

### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

<table>
<thead>
<tr>
<th>Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care</td>
</tr>
<tr>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Assistive Services</td>
</tr>
<tr>
<td>Behavior Therapy</td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
</tr>
<tr>
<td>Enhanced Care Services</td>
</tr>
<tr>
<td>Home-Delivered Meals Service</td>
</tr>
<tr>
<td>Medication Reminder Services</td>
</tr>
<tr>
<td>Personal Emergency Response System and Installation</td>
</tr>
<tr>
<td>Transitional Living Skills</td>
</tr>
</tbody>
</table>

### 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**
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care Total:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9668436.54</td>
</tr>
<tr>
<td>Personal Services - agency-direct</td>
<td>×</td>
<td>15 minutes</td>
<td>242</td>
<td>4764.84</td>
<td>3.49</td>
<td>4024288.57</td>
<td></td>
</tr>
<tr>
<td>Personal Services - self-direct</td>
<td>×</td>
<td>15 minutes</td>
<td>321</td>
<td>5764.04</td>
<td>3.06</td>
<td>5644147.97</td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy Total:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>366546.34</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>×</td>
<td>15 minutes</td>
<td>74</td>
<td>191.47</td>
<td>25.87</td>
<td>366546.34</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td>557624.01</td>
</tr>
<tr>
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<td>15 minutes</td>
<td>89</td>
<td>251.75</td>
<td>25.74</td>
<td>557624.00</td>
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</tr>
<tr>
<td><strong>Speech and Language Therapy Total:</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>287180.29</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>×</td>
<td>15 minutes</td>
<td>53</td>
<td>211.66</td>
<td>25.60</td>
<td>287180.29</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Management Services Total:</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>390983.77</td>
</tr>
<tr>
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<td>×</td>
<td>1 month</td>
<td>342</td>
<td>9.29</td>
<td>123.06</td>
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<td><strong>Assistive Services Total:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>22763.53</td>
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<tr>
<td>Assistive Services</td>
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<td>11</td>
<td>1.26</td>
<td>1642.39</td>
<td>22763.53</td>
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<tr>
<td>Behavior Therapy</td>
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<td>284.56</td>
<td>21.34</td>
<td>473655.81</td>
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<td><strong>Cognitive Rehabilitation Total:</strong></td>
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<td></td>
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<td>511278.40</td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
<td>×</td>
<td>15 minutes</td>
<td>128</td>
<td>187.97</td>
<td>21.23</td>
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<td></td>
<td></td>
<td></td>
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</tr>
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<td>Enhanced Care Services</td>
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<td>1 unit</td>
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<td>2072380.15</td>
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</tr>
<tr>
<td><strong>Home-Delivered Meals Service Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Home-Delivered Meals Service</td>
<td>×</td>
<td>1 meal</td>
<td>203</td>
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<td>14591.96</td>
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<tr>
<td>Medication Reminder</td>
<td>×</td>
<td>1 month</td>
<td>1</td>
<td>3.00</td>
<td>17.04</td>
<td>14591.96</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

Total: Services included in capitation: 17987061.01
Total: Services not included in capitation: 17987063.01
Total Estimated Unduplicated Participants: 723
Factor D (Divide total by number of participants): 24878.37
Services included in capitation: 24878.37
Services not included in capitation: 24878.37

Average Length of Stay on the Waiver: 314
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Total:</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personal Services - agency-direct</td>
<td>X</td>
<td>15 minutes</td>
<td>242</td>
<td>4764.84</td>
<td>3.49</td>
<td>4024288.57</td>
<td></td>
</tr>
<tr>
<td>Personal Services - self-direct</td>
<td>X</td>
<td>15 minutes</td>
<td>320</td>
<td>5764.04</td>
<td>3.06</td>
<td>564447.97</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

- Total: Services included in capitation: 17987061.01
- Total: Services not included in capitation: 17987061.01
- Total Estimated Unduplicated Participants: 723
- Factor D (Divide total by number of participants): 24.87
- Services included in capitation: 24.87
- Services not included in capitation: 24.87
- Average Length of Stay on the Waiver: 314
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td>366546.34</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
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<td></td>
<td></td>
<td>576724.01</td>
</tr>
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<tr>
<td>Speech and Language</td>
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<td></td>
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<td>22763.53</td>
</tr>
<tr>
<td>Behavior Therapy</td>
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<td></td>
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</tr>
<tr>
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<td>Cognitive Rehabilitation</td>
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<td></td>
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<td>2072380.15</td>
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<tr>
<td>Home-Delivered Meals</td>
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</tr>
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<td>Service Total:</td>
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<td></td>
<td></td>
<td>457056.69</td>
</tr>
<tr>
<td>Medication Reminder</td>
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<td></td>
</tr>
<tr>
<td>Services Total:</td>
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<tr>
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</tr>
</tbody>
</table>

GRAND TOTAL: 17987061.01

Total: Services included in capitation: 17987061.01

Total: Services not included in capitation: 0

Total Estimated Unduplicated Participants: 723

Factor D (Divide total by number of participants): 24878.37

Services included in capitation: 24878.37

Services not included in capitation: 0

Average Length of Stay on the Waiver: 314
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Services - agency-direct</td>
<td>x</td>
<td>15 minutes</td>
<td>242</td>
<td>4764.84</td>
<td>3.49</td>
<td>4024288.57</td>
<td></td>
</tr>
<tr>
<td>Personal Services - self-direct</td>
<td>x</td>
<td>15 minutes</td>
<td>320</td>
<td>5764.04</td>
<td>3.06</td>
<td>5644147.97</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>x</td>
<td>15 minutes</td>
<td>74</td>
<td>191.47</td>
<td>25.87</td>
<td>366546.34</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
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</tr>
<tr>
<td>Grand Total:</td>
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Total: Services included in capitation: 17987061.01

Total: Services not included in capitation: 723

Factor D (Divide total by number of participants): 24878.37

Services included in capitation: 24878.37

Services not included in capitation: 723

Average Length of Stay on the Waiver: 314
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**GRAND TOTAL:**

| Total: Services included in capitation: | 17987061.01 |
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| Total: Estimated Unduplicated Participants: | 723 |
| Factor D (Divide total by number of participants): | 24878.37 |
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Average Length of Stay on the Waiver: 314
### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

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**Average Length of Stay on the Waiver:** 314
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J-2: Derivation of Estimates (9 of 9)

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07/05/2023
Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of Kansas requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
   Kansas Physical Disability Waiver

C. Waiver Number: KS.0304
   Original Base Waiver Number: KS.0304.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
   01/01/24

Approved Effective Date of Waiver being Amended: 01/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

To align this waiver with the submission of the State's 1915(b) application.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
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<tr>
<td>Waiver Application</td>
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<td>Appendix A</td>
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<td>Waiver Administration and Operation</td>
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<td>Appendix B</td>
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</table>
### Component of the Approved Waiver

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
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<tbody>
<tr>
<td>Participant Access and Eligibility</td>
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<td>Appendix C Participant Services</td>
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<td>Appendix D Participant Centered Service Planning and Delivery</td>
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<td>Appendix E Participant Direction of Services</td>
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<td>Appendix G Participant Safeguards</td>
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<td>Appendix I Financial Accountability</td>
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<td>Appendix J Cost-Neutrality Demonstration</td>
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### B. Nature of the Amendment

Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

---

**Application for a §1915(c) Home and Community-Based Services Waiver**

1. Request Information (1 of 3)

   **A.** The **State** of **Kansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (optional - this title will be used to locate this waiver in the finder):

Kansas Physical Disability Waiver

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

- 3 years
- 5 years

Original Base Waiver Number: KS.0304
Draft ID: KS.014.05.04

D. Type of Waiver (select only one):

- Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/20
   Approved Effective Date of Waiver being Amended: 01/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

- Hospital
  Select applicable level of care
    - Hospital as defined in 42 CFR §440.10
      If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

    - Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

- Nursing Facility
  Select applicable level of care
    - Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

07/05/2023
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

- Not applicable

- Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- Not applicable

- Applicable

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

- Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

This amendment is being submitted simultaneously with the 1915(b) application.

Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)

- §1915(b)(2) (central broker)

- §1915(b)(3) (employ cost savings to furnish additional services)

- §1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.
2. Brief Waiver Description

**Brief Waiver Description.** In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Kansas Physical Disability (PD) waiver is to provide eligible Kansans the option to receive services in their home and community rather than in a more expensive, less-integrated nursing home setting. PD services are available to individuals who are between 16 and 64 years of age, have a documented physical disability as determined by the Social Security Disability Administration, who meet the level of care for Nursing Facility admission, and who are financially eligible for Medicaid.

The State contracts with Aging and Disability Resource Centers (ADRC) to conduct the initial and annual functional eligibility assessments as well as performing information and referrals. Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community Based Services (HCBS) services as one part of the comprehensive KanCare program.

Services available through the PD waiver are: Assistive Services, Enhanced Care Services, Financial Management Services, Home-Delivered Meals, Medication Reminder Services and Installation, Personal Care Services, and Personal Emergency Response System and Installation.

The state offers agency directed options for all PD waiver services. There are opportunities for waiver participants to self-direct certain services within the PD waiver.

Entry into the waiver is based on a first-come, first-served basis for participants determined eligible. In the event there is a waiting list, entry is based on the date the functional assessment is completed. Responsibility for managing the waitlist remains with KDADS.

3. Components of the Waiver Request

The waiver application consists of the following components. Note: **Item 3-E must be completed.**

- **A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.

- **B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

- **C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

- **D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

- **E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (Select one):
  - Yes. This waiver provides participant direction opportunities. Appendix E is required.
  - No. This waiver does not provide participant direction opportunities. Appendix E is not required.

- **F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

- **G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (select one):

- Not Applicable
- No
- Yes

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (select one):

- No
- Yes

If yes, specify the waiver of statewideness that is requested (check each that applies):

- Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in Appendix C.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designated parties, 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, if applicable, his or her legal representative) 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 habilitative 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 clinical 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 inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in Appendix I.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in Appendix C.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. Appendix F specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in Appendix H.

I. Public Input. Describe how the state secures public input into the development of the waiver:

A public notice was not required as this is not a substantive change. The Tribal Notice was posted June 10, 2021 and ended June 24, 2021. The Tribal Notice did not elicit any comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 -
August 8, 2003). Appendix B describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

### 7. Contact Person(s)

#### A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Graff-Hendrixson</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Bobbie</td>
</tr>
<tr>
<td>Title</td>
<td>Director of Compliance and Contracting</td>
</tr>
<tr>
<td>Agency</td>
<td>Kansas Department of Health and Environment</td>
</tr>
<tr>
<td>Address</td>
<td>Landon State Office Building, Room 900N</td>
</tr>
<tr>
<td>Address 2</td>
<td>900 SW Jackson Street</td>
</tr>
<tr>
<td>City</td>
<td>Topeka</td>
</tr>
<tr>
<td>State</td>
<td>Kansas</td>
</tr>
<tr>
<td>Zip</td>
<td>66612-1220</td>
</tr>
<tr>
<td>Phone</td>
<td>(785) 296-0149</td>
</tr>
<tr>
<td>Fax</td>
<td>(785) 296-4813</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:Bobbie.Graff-Hendrixson@ks.gov">Bobbie.Graff-Hendrixson@ks.gov</a></td>
</tr>
</tbody>
</table>

#### B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Cintron</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Christopher</td>
</tr>
<tr>
<td>Title</td>
<td>PD Program Manager</td>
</tr>
<tr>
<td>Agency</td>
<td>Kansas Department for Aging and Disability Services/Community Services &amp; Programs</td>
</tr>
<tr>
<td>Address</td>
<td>New England Building</td>
</tr>
<tr>
<td>Address 2</td>
<td></td>
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</tbody>
</table>
8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state’s request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: 

State Medicaid Director or Designee

Submission Date: 

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: 
First Name: 
Title: 
Agency: 
Address: 
Address 2: 
City: 
State: Kansas 
Zip:
Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

The State does not anticipate any impact on waiver participants, the decrease to Factor C is not restricting eligibility, but instead is a technical adjustment to reflect actual utilization patterns.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state’s process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state’s HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter “Completed” in this field, and include in Section C-5 the information on all HCB settings in the waiver.
The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state’s most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

**Additional Needed Information (Optional)**

Provide additional needed information for the waiver (optional):

- Not applicable

**Appendix A: Waiver Administration and Operation**

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver *(select one)*:
   - The waiver is operated by the state Medicaid agency.
     - Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:
       - The Medical Assistance Unit.
         - Specify the unit name:

   *(Do not complete item A-2)*

   - Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.
     - Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   *(Complete item A-2-a)*.

   - The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.
     - Specify the division/unit name:
       - Kansas Department for Aging and Disability Services

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b)*.

**Appendix A: Waiver Administration and Operation**

2. **Oversight of Performance.**
   
   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.
b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
   - Information received from CMS;
   - Proposed policy changes;
   - Waiver amendments and changes;
   - Data collected through the quality review process;
   - Eligibility, numbers of participants being served;
   - Fiscal projections; and
   - Any other topics related to the waivers and Medicaid
b. All policy changes related to the waivers are approved by KDHE.
c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the programs, in collaboration with the operating agency, and the KanCare MCO contracts, including those items identified in part (a) above. The key component of that collaboration be through the interagency monitoring, an important part of the overall state’s KanCare Quality Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state’s KanCare Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA’s monitoring of delegated functions to the Operating Agency) is guided by the KanCare Quality Strategy. A critical component of that strategy is the engagement of the interagency monitoring, which bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including interagency monitoring meetings – occur on a quarterly basis. While
continuous monitoring is conducted, including monthly and other intervals, the aggregation, analysis and trending processes is built around that quarterly structure.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (select one):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
  Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6:

  KDADS contracts with the Aging and Disability Resource Centers (ADRC) to receiving referrals, provide options counseling, complete the standard intake and conduct the functional eligibility assessment for the PD waiver.

  The MCOs, or their designee, conduct a comprehensive needs assessment, develop the Person-Centered Service Plan (which includes both waiver and state plan services), assist the participant in developing the Participant Interest Inventory (PII), offer provider choice, offer choice between self or agency direction, conduct provider credentialing, conduct provider training, monitor of service delivery and participate in the comprehensive state quality improvement strategy for the KanCare program.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (Select One):

- Not applicable
- Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:

  Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

  Specify the nature of these agencies and complete items A-5 and A-6:

  Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  Specify the nature of these entities and complete items A-5 and A-6:
The Aging and Disability Resource Centers (ADRC) are contracted by KDADS to provide Health and Community Based Services (HCBS) assessments to individuals wanting to obtain waiver services through the Physical Disability (PD) waiver. The ADRC performs the assessment and the state system determines the Level of Care score. The ADRC does not make the determination, the data is provided to the state to be calculated by the state MIS. The scores are then calculated by the state to determine level of care (LOC) eligibility. In addition to assessing individuals for HCBS waivers, the ADRC’s also provide Options Counseling to individuals to educate them on services available within their community. The ADRC’s also operate a call-center that provides information, referrals, and assistance to individuals statewide.

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Kansas Department for Aging and Disability Services.

KDHE completes oversight of KDADS through monthly Long-Term Care meetings in which KDADS submits reports to KDHE regarding LOC eligibility determinations.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Contracted entities, including both contracted entities/providers and the state’s contracted MCOs, are monitored through the HCBS Quality Strategy (appendix H). All functions delegated to contracted entities are included in the HCBS quality review processes. A key component of that monitoring and review process is collaboration between KDHE and KDADS which includes HCBS waiver management staff from the Kansas Department for Aging and Disability Services (KDADS). In addition, the SSMA and the State Operating Agency will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will include oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors.

The HCBS Quality Strategy ensures that the entities contracting with KDADS are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1915 (b) waiver, Kansas statutes and regulations, and related policies.

KDHE monitors KDADS’ development of operational processes and collaborates with KDADS to ensure that appropriate administrative oversight components are specified in those processes. Through existing KDHE policy review processes and monthly KDHE Long Term Care (LTC) meeting updates/reports, KDHE ensures implementation of the operational processes.

Oversight of the ADRCs and the MCOs is conducted on a quarterly basis via the KDADS Quality Review process. In instances where KDADS is primarily responsible for conducting the quality review, KDADS analyzes and compiles the performance results and reports the findings and summaries to the Medicaid agency.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than
one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
<th>Local Non-State Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant waiver enrollment</td>
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<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiver enrollment managed against approved limits</td>
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<td></td>
</tr>
<tr>
<td>Waiver expenditures managed against approved levels</td>
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<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of care evaluation</td>
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<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>Review of Participant service plans</td>
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<td>X</td>
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<td>X</td>
</tr>
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<td>Prior authorization of waiver services</td>
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<td>Utilization management</td>
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<tr>
<td>Qualified provider enrollment</td>
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<td>Execution of Medicaid provider agreements</td>
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<td>Establishment of a statewide rate methodology</td>
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</tr>
<tr>
<td>Rules, policies, procedures and information development governing the waiver program</td>
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</tr>
<tr>
<td>Quality assurance and quality improvement activities</td>
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<td>X</td>
</tr>
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</table>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and Percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Tracked by Program Manager

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<tr>
<th>Responsible Party for data collection/generation</th>
<th>Frequency of data collection/generation</th>
<th>Sampling Approach</th>
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<td>State Medicaid Agency</td>
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<tr>
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</tr>
<tr>
<td>Sub-State Entity</td>
<td>× Quarterly</td>
<td>Representative Sample</td>
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<td>Stratified Describe Group:</td>
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Data Aggregation and Analysis:

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### Performance Measure:
Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency. 
N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the state Medicaid Agency. 
D=Number of Quality Review reports.

### Data Source (Select one):
- Other
  - If 'Other' is selected, specify: Tracked by Program Manager

### Responsible Party for data collection/generation (check each that applies):

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<th>Frequency of data collection/generation (check each that applies):</th>
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</table>

**Performance Measure:**
Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency

N=Number of waiver amendments and renewals and approved by the State Medicaid Agency prior to submission to CMS
D=Total number of waiver amendments and renewals

**Data Source (Select one):**
Other
If 'Other' is selected, specify:
Tracked by Program Manager
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<tr>
<th>Performance Measure:</th>
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<td>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</td>
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### Data Source (Select one):
- Other
  - If 'Other' is selected, specify: Quality Review Reports

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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
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### ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Quality Management Specialists during the Quality Survey process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. The Managed Care Organizations are engaged with state staff to ensure a strong understanding of Kansas’ waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

### b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on
the methods used by the state to document these items.

KDHE and KDADS have a standing weekly policy meeting to review all KDADS and KDHE policies prior to finalization and public posting. KDHE assigns policy numbers to all final KDADS’ policies. No policy may be assigned a policy number without being reviewed and approved by KDHE at the weekly meeting.

KDADS Quality Management Staff have a standing schedule and timeline by which reviews must be completed and a report generated. The results of the quality reviews are submitted to the KDHE and KDADS Long Term Care meeting for review. Any issues with the reports are discussed and follow up action assigned during those meetings. In addition, KDADS Quality Staff and HCBS Program Staff meet monthly to discuss findings from the quality reviews and any process changes that are needed.

The HCBS Director is responsible for ensuring attendance of HCBS Program Managers at the monthly Long-Term Care meetings. Any disciplinary action needed is handled by the HCBS Director.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

<table>
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<th>Responsible Party (check each that applies):</th>
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<td>Continuously and Ongoing</td>
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</table>

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

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:

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age Limit</th>
<th>No Maximum Age Limit</th>
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<tr>
<td>Aged</td>
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<td>Disabled (Other)</td>
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</tr>
<tr>
<td><strong>Aged or Disabled, or Both - Specific Recognized Subgroups</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Fragile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intellectual Disability or Developmental Disability, or Both</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Illness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious Emotional Disturbance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. Additional Criteria. The state further specifies its target group(s) as follows:

Participants who are approaching their 65th birthday have a choice of remaining on the PD waiver or transitioning to the Frail Elderly (FE) waiver provided they meet established eligibility criteria.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

- Not applicable. There is no maximum age limit
- The following transition planning procedures are employed for participants who will reach the waiver’s maximum age limit.

Specify:

KanCare MCOs consult with participants to discuss differences in waiver services between the FE and PD waivers and determine the participants' choice on which waiver they would like to be served by. The process for transitions from the PD waiver to the FE waiver is established in the HCBS Physical Disability Transition policy.
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:
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:

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>6898</td>
</tr>
<tr>
<td>Year 2</td>
<td>6898</td>
</tr>
<tr>
<td>Year 3</td>
<td>6898</td>
</tr>
<tr>
<td>Year 4</td>
<td>6898</td>
</tr>
<tr>
<td>Year 5</td>
<td>6898</td>
</tr>
</tbody>
</table>

Table: B-3-b

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:

<table>
<thead>
<tr>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD Participants in the Custody of DCF</td>
</tr>
<tr>
<td>Temporary Institutional Stay</td>
</tr>
<tr>
<td>WORK Program</td>
</tr>
<tr>
<td>HCBS Institutional Transitions</td>
</tr>
<tr>
<td>Military Inclusion</td>
</tr>
</tbody>
</table>
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):

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD Participants in the Custody of DCF</td>
<td>The State reserves capacity for PD waiver participants age 16-19 years who are in the custody of DCF in accordance with the HCBS Access for individuals in the custody of DCF policy.</td>
</tr>
</tbody>
</table>

Describe how the amount of reserved capacity was determined:

The number of reserved capacity is based on actual PD waitlist data.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Institutional Stay</td>
<td>The state reserves capacity to maintain continued waiver eligibility for participants who enters into an institution such as hospitals, ICF/ID or nursing facilities for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services at a later date and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.</td>
</tr>
</tbody>
</table>

Describe how the amount of reserved capacity was determined:

Historical information data are used to determine slots. Individuals already on waiver services can access temporary institutional care, while those not on waiver services goes through the institutional transition process.
The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>150</td>
</tr>
<tr>
<td>Year 2</td>
<td>150</td>
</tr>
<tr>
<td>Year 3</td>
<td>150</td>
</tr>
<tr>
<td>Year 4</td>
<td>150</td>
</tr>
<tr>
<td>Year 5</td>
<td>150</td>
</tr>
</tbody>
</table>

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

WORK Program

Purpose (describe):

The State reserves capacity for PD program participants who have participated in the WORK program have the option to return to the program and bypass the wait list if the program maintains a waitlist. Consistent with CMS required annual eligibility re-determination participants must be reassessed within 90 days of leaving the WORK program in accordance with program eligibility level of care requirements. If the consumer is determined to not meet level of care eligibility, KDADS will terminate services using established process, including appeal rights.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined using actual number of past participants who transition back to the PD waiver from the WORK program.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

HCBS Institutional Transitions
**Purpose** *(describe):*

The State reserves capacity for individuals transitioning from an approved institutional setting to the PD waiver in accordance with the HCBS Institutional Transition Policy.

Describe how the amount of reserved capacity was determined:

Institutional transition reserve capacity is based on historical data that show the number of people who have chosen to transition from an approved institutional setting to the PD waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>110</td>
</tr>
<tr>
<td>Year 2</td>
<td>110</td>
</tr>
<tr>
<td>Year 3</td>
<td>110</td>
</tr>
<tr>
<td>Year 4</td>
<td>110</td>
</tr>
<tr>
<td>Year 5</td>
<td>110</td>
</tr>
</tbody>
</table>

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**Purpose** *(provide a title or short description to use for lookup):*

**Military Inclusion**

**Purpose** *(describe):*

The State reserves capacity for military participants and their immediate dependent family members who have been determined program eligible may bypass waitlist upon approval by KDADS. Individuals who have been determined to meet the established PD waiver criteria will be allowed to bypass the waitlist and access services.

Describe how the amount of reserved capacity was determined:

Slots are determined through an analysis of military personnel accessing this waiver service and there are no data to support projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (select one):

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

1. PD waiver eligibility criteria is defined in the HCBS Physical Disability Eligibility policy.
2. The waitlist process and procedures are identified in the HCBS Physical Disability Eligibility policy.
3. The process and procedures for applying for a crisis exception to the PD waiting list are identified in the HCBS Physical Disability Crisis Exception policy.
4. The HCBS Institutional Transition policy identifies the process and procedures for allowing eligible individuals discharging from an approved institutional setting to bypass the PD waitlist and access the waiver.
5. The Military Inclusion policy identifies the process and procedures for eligibility military participants and their immediate dependent family members (as defined by IRS) to bypass the PD waitlist and access waiver services.
6. The KDADS WORK Transition policy details the process for individuals to access the waiver from the WORK program.
7. The process to transition from the BI waiver to the PD waiver is specified in the TBI Transition policy.

Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. The PD waiver has a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the waiting list remains with the State (KDADS).

Participants may supersede the waiting list process if they fall into one of the following groups:
- Children under DCF custody
- Participants transferring directly from another HCBS waiver such as Technology Assistance (TA) and Brain Injury (BI).
- Participants exiting a Medicaid approved nursing facility through the HCBS Institutional Transition Policy.
- The reserve capacity groups other than children in DCF custody, people receiving a crisis exception, and people who are transferring from the WORK program.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.
Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (select one):
   - §1634 State
   - SSI Criteria State
   - 209(b) State

2. Miller Trust State.
   Indicate whether the state is a Miller Trust State (select one):
   - No
   - Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. Check all that apply:

   **Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

   - Low income families with children as provided in §1931 of the Act  
   - SSI recipients
     - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
     - Optional state supplement recipients
     - Optional categorically needy aged and/or disabled individuals who have income at:
       - Select one:
         - 100% of the Federal poverty level (FPL)
         - X % of FPL, which is lower than 100% of FPL.

       Specify percentage: [ ]

   - Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
   - Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
   - Medically needy in 209(b) States (42 CFR §435.330)
   - Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
   - Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

   Specify:

   - Parents and other caretaker relatives (42 CFR 435.110)

**Special home and community-based waiver group under 42 CFR §435.217** Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed
No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:
  - Select one:
    - 300% of the SSI Federal Benefit Rate (FBR)
    - A percentage of FBR, which is lower than 300% (42 CFR §435.236)
      - Specify percentage: 
    - A dollar amount which is lower than 300%.
      - Specify dollar amount: 
  - Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
  - Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
    - Medically needy without spend down in 209(b) States (42 CFR §435.330)
    - Aged and disabled individuals who have income at:
      - Select one:
        - 100% of FPL
        - % of FPL, which is lower than 100%.
          - Specify percentage amount: 
      - Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)
        - Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility
for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

× Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

○ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

○ Use spousal post-eligibility rules under §1924 of the Act.
  (Complete Item B-5-b (SSI State) and Item B-5-d)

○ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

○ The following standard included under the state plan

Select one:

○ SSI standard
○ Optional state supplement standard
○ Medically needy income standard
○ The special income level for institutionalized persons

(select one):

○ 300% of the SSI Federal Benefit Rate (FBR)
○ A percentage of the FBR, which is less than 300%

Specify the percentage: [ ]
- A dollar amount which is less than 300%.
  Specify dollar amount:

- A percentage of the Federal poverty level
  Specify percentage:

- Other standard included under the state Plan
  Specify:

- The following dollar amount
  Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:
  Specify:

- Other
  Specify:

ii. Allowance for the spouse only (select one):
- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
  Specify:

  Specify the amount of the allowance (select one):
- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The following dollar amount:
  Specify dollar amount: If this amount changes, this item will be revised.
- The amount is determined using the following formula:
  Specify:
iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:

  Specify:

  [ ] Other

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

  a. Health insurance premiums, deductibles and co-insurance charges
  b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.
- The state does not establish reasonable limits.
- The state establishes the following reasonable limits

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.
Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage: [ ]

- The following dollar amount:

Specify dollar amount: [ ] If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:

Specify formula:

- Other

Specify:

300% of SSI

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:
   
a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.
- The state does not establish reasonable limits.
- The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.


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.


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.


The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.
a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state’s policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The state requires (select one):

  - The provision of waiver services at least monthly
  - Monthly monitoring of the individual when services are furnished on a less than monthly basis

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

  - Directly by the Medicaid agency
  - By the operating agency specified in Appendix A
  - By a government agency under contract with the Medicaid agency.

*Specify the entity:*

  - Other
*Specify:*

The Aging and Disability Resource Centers (ADRC) contract with the State and are responsible for performing the evaluation and reevaluation for level of care determination as indicated in appendix A of this application. The ADRC performs the assessment and the state system determines the Level of Care score. The ADRC does not make the determination, the data is provided to the state to be calculated by the state MIS.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:
Qualifications of ADRC functional eligibility assessor:

Four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the ADRC contractor; or a Registered Nurse license to practice in the state of Kansas. The ADRC is responsible for verifying assessor experience, education and certification requirements are met for assessors. The contractor must maintain these records for five (5) years following termination of employment.

Functional eligibility assessors must attend initial certification and recertification training sessions according to KDADS’ Policy. Functional eligibility assessors must successfully complete FEI and Kansas Aging Management Information System (KAMIS) training prior to performing any functional eligibility assessment.

A functional eligibility assessor that has not conducted any functional assessments within the last six months must repeat the training and certification requirements for the FEI.

KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all FEI assessors. KDADS shall provide training materials and written documentation of successful completion of training. Assessors must participate in all state-mandated trainings to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by KDADS. Tracking staff training is the responsibility of the contractor and should be recorded in the manner required by KDADS.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state’s level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Participants with a physical disability must meet the level of care required for Medicaid Nursing Facility placement. See Appendix B-1 for the functional and programmatic eligibility criteria for the PD waiver.

The level of care is determined by utilizing the functional eligibility instrument (FEI). The FEI is an assessment of an individual's capacity to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and measures an individual's and cognitive limitations that will be critical to the development of a participant's Person-Centered Service Plan.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.
- A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:
The ADRC shall perform conflict free functional eligibility assessments. The level of care criteria utilized for initial assessments of PD waiver participants and yearly reassessments of waiver participants is the same. Participants must meet the Medicaid Long Term Care threshold score based on an assessment completed with the functional eligibility instrument (FEI). The contracted assessors will screen for reasonable indicators of meeting the level of care eligibility prior to administering the functional eligibility instrument. The level of care assessment and reassessment process is conducted by a qualified assessor contracted with Kansas.

Information used to determine scores and other eligibility criteria can come from a variety of sources. The participant is the primary source of information. The assessing entity uses interview techniques that are considerate of any limitations the participant might have with hearing, eyesight, cognition, etc. Family members and other individuals who might have relevant information about the participant can also be interviewed. The contracted assessors may also use clinical records, if available, and/or discuss the participant's status with the appropriate medical professional when authorized by the participant.

All community referrals may contact the assessing entity directly and they will intake pertinent referral information and conduct preliminary screening for reasonable indicators of meeting the program level of care criteria. In the event a participant has a primary diagnosis of I/DD, the assessor must make a referral to the CDDO, in the area which the participant resides, for evaluation.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (specify):

Timely re-evaluation requirements are also included in the State's contract with the ADRC. Assurance that timely re-evaluations are conducted are monitored through the KDADS quarterly quality review process. In the event the contractor does not meet the requirements, KDADS issues a corrective action plan which requires the contractor to detail their remediation strategy to come into compliance. The ADRC receives a monthly reassessment report from KDADS with a list of all waiver participants that have assessments expiring within 30 days.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:
Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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

\[ N = \text{Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services} \]
\[ D = \text{Total number of enrolled waiver participants} \]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

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Confidence Interval = 95% +/- 5%

Other
Specify:

Contracted assessors and Managed Care Organizations (MCOs)

Anually

Stratified
Describe Group:

Continuously and Ongoing

Other
Specify:

Data Aggregation and Analysis:

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| Other
  Specify: | Contracted assessors participate in analysis of this measure's results as determined by the State operating agency | Annually |
| | Continuously and Ongoing | Other
  Specify: |
b. **Sub-assurance:** The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination

\[ N = \text{Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination} \]

\[ D = \text{Number of waiver participants who received Level of Care redeterminations} \]

**Data Source** (Select one):

- **Other**

If 'Other' is selected, specify:

Operating agency’s data system: "Kansas Assessment Management Information (KAMIS)/System or its related web applications"

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### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied

\[ N = \text{Number of initial Level of Care (LOC) determinations made} \]

\[ D = \text{Number of LOC determinations made where the LOC criteria was accurately applied} \]
initial Level of Care determinations

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

Record Reviews

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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

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| ✗ Other  
Specify:  
Contracted assessors participate in analysis of this measure's results as determined by the State operating agency | Annually |
| Continuous and Ongoing | Other  
Specify: |

**Performance Measure:**
Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool  
N=Number of waiver participants whose Level of Care determinations used the approved screening tool  
D=Number of waiver participants who had a Level of Care determination

**Data Source** (Select one):
- Record reviews, on-site
  
  If ’Other’ is selected, specify:
Record reviews

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures are a part of the HCBS quality strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of the functional eligibility contractors with Kansas will be monitored on an ongoing basis to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency. State staff request, approve, and assure implementation of corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through the quality review process. These processes are monitored by both program managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the HCBS quality strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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KanCare MCOs participate in analysis
c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix B: Participant Access and Eligibility

**B-7: Freedom of Choice**

*Freedom of Choice.* As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Before the functional eligibility evaluation is conducted, as a part of the referral process the ADRC educates the individual on their choices of community-based programs as well as the institutional equivalent. The ADRC assessor documents the individuals' choice of Home and Community-based services on the eligibility communication form (E-3160) used by the state. In addition, during the Person-Centered Service Plan development process, the KanCare MCO selected by the participant informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the PD Waiver Participant Choice Form.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

PD Waiver Participant Choice forms are documented and maintained in the participant’s file by the functional eligibility assessor and the participant's chosen KanCare MCO.

Appendix B: Participant Access and Eligibility

**B-8: Access to Services by Limited English Proficiency Persons**

*Access to Services by Limited English Proficient Persons.* Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. To comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information. This information is captured in the Functional Eligibility Instrument (FEI).

The State of Kansas defines prevalent non-English languages as languages spoken by significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that 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).

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:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Personal Care Services</td>
</tr>
<tr>
<td>Supports for Participant Direction</td>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Assistive Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Enhanced Care Service</td>
</tr>
<tr>
<td>Other Service</td>
<td>Home-Delivered Meals Service</td>
</tr>
<tr>
<td>Other Service</td>
<td>Medication Reminder Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Personal Emergency Response System and Installation</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
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</tr>
</thead>
</table>

Service:

<table>
<thead>
<tr>
<th>Personal Care</th>
</tr>
</thead>
</table>

Alternate Service Title (if any):

| Personal Care Services |

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 Home-Based Services</td>
<td>08030 personal care</td>
</tr>
<tr>
<td>Category 2:</td>
<td>Sub-Category 2:</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 3:</td>
<td>Sub-Category 3:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Definition <em>(Scope)</em>:</td>
<td>Sub-Category 4:</td>
</tr>
<tr>
<td>Category 4:</td>
<td></td>
</tr>
</tbody>
</table>
Personal Care Services (PCS) includes supports for the participant in the following areas:

1. Activities of Daily Living (ADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy.

2. Health maintenance activities (HMA) in accordance with the Personal Care Services and Limitations policy.

3. Instrumental Activities of Daily Living (IADLs) in accordance with K.A.R. 30-5-300 and the Personal Care Services and Limitations policy.

4. Assistance and accompaniment for exercise, socialization and recreation activities.

5. Assistance accessing medical care.

PCS are individualized (one-to-one) services provided during times when the participant is not typically sleeping. The cost associated with the provider travelling to deliver this service is included in the rate paid to the provider. Non-emergency Medical Transportation (NEMT) is a State Plan service and can be accessed through the MCO.

The service must occur in a home or community location meeting the setting requirements as defined in the “HCBS Setting Final Rule.” Home is where the participant makes his or her residence and must not be defined as institutional in nature. A family is defined as any person immediately related to the participant, such as: parents/legal guardian, spouse, siblings; or when the participant lives with other persons capable of providing the care as a part of the informal support system.

Informal/natural supports may include relatives and friends that live with the waiver participant. An informal/natural support, who is capable of providing assistance with IADL tasks, may not be paid to perform these tasks when they can be completed in conjunction with normal household duties. If a capable, informal/natural support refuses or is unable to provide assistance with the IADL tasks, the refusal or inability must be documented in writing, signed by the informal/natural support and included in the Service Plan. In these instances, the MCO may authorize the individual to receive self-directed or agency-directed formal support for the authorized IADL tasks. The individual may choose to self-direct; however, the self-directed worker may not be the capable, informal/natural support who has refused or is incapable of performing assistance with the IADLs as a part of normal household duties. Unless there are extenuating or specific circumstances that are documented in the Service Plan, waiver participants should rely on informal/natural supports who are capable and willing to provide assistance with IADLs when they can be completed in conjunction with normal household duties. The IADL tasks that can be completed in conjunction with normal household duties include: lawn care, snow removal, shopping, housekeeping, laundry, and meal preparation. The capable, informal/natural support may be paid for laundry, housekeeping, and meal prep under the following circumstances:

**Meal Prep:**
The waiver participant has a specialized diet that is prescribed by a physician and either requires specialized preparation or is designed specifically to meet the participant’s dietary needs as documented in the Service Plan. PCS shall only be authorized for the time spent preparing the waiver participant’s specialized diet. A specialized diet does not include simple differences in ingredients, preparing the same meal slightly different to meet the participant’s dietary restrictions.

**Housekeeping:**
The waiver participant has documented incontinence issues or other specialized needs that create excessive housekeeping. Homemaker/chore services provided as part of PCS can only be incidental, and cannot comprise the entirety of the service. PCS performed should be specific to the needs of the waiver recipient as reflected in the personal care service plan.

**Laundry:**
The waiver participant has documented incontinence issues creating excessive laundry. PCS shall only be authorized for the time spent providing assistance with the participant’s excessive laundry. One unit of service equals 15 minutes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
To avoid overlap of services, PCS is limited to those services not covered through EPSDT, the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant’s Person-Centered Service Plan.

Personal Care Services provided in a home school setting must not be educational in purpose.

The scope, duration and amount of services authorized by the MCO shall be consistent with the participant’s assessed need as documented in the Person-Centered Service Plan.

Personal Services is limited to up to 12 hours per 24-hour day (a unit of service is 15 minutes). The MCO may authorize services exceeding 12 hours per 24-hours if the participant meets one or more of the following criteria:
1. The additional request for PCS is critical to the remediation of the participant’s abuse neglect, exploitation, or domestic violence issue.
2. The additional request for PCS is critical to the participant’s ability to remain in the community in lieu of an institution.
3. The time additional request for PCS is a necessary support in order for the participant to remain in the community within the first three months of his/her return to the community from a prolonged stay (greater than 90 days) in an institution.

A person may have several PCS workers providing care on a variety of days at a variety of times, but a person may not have more than one PCS worker providing care at any given time. Person-Centered Service Plans for which it is determined that the provision of Personal Care Services would be a duplication of services will not be approved. The MCO will not make payments for multiple claims filed for the same time on the same date of service.

Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with Intellectual Developmental Disability (IDD), or institution for mental disease are not covered.

Self-Directed PCS will be paid through an enrolled fiscal management service agency.

Children receiving care in licensed foster care settings do not have the option to self-direct services. All services must be provided through the agency directed service model.

While Federal rules generally prohibit payments to legally responsible relatives for Personal Care Services, Kansas does allow such payments under the circumstances described in Appendix C-2-d. Legally responsible individuals who have a duty under State law to care for another person include:
(a) the parent (biological or adoptive) of a minor child; or the guardian of a minor child who must provide care to the child; or
(b) a spouse of a waiver participant

Service Delivery Method (check each that applies):

- [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
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Personal Care Attendant/Personal Care Services provider</td>
</tr>
<tr>
<td>Agency</td>
<td>Home Health Agency</td>
</tr>
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</table>

07/05/2023
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

<table>
<thead>
<tr>
<th>Provider Category:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Provider Type:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Attendant/Personal Care Services provider</td>
<td></td>
</tr>
</tbody>
</table>

**Provider Qualifications**

**License (specify):**

- Not applicable

**Certificate (specify):**

- Not applicable

**Other Standard (specify):**

- A. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider
- B. Must have a High School Diploma or equivalent OR be at least eighteen years of age or older;
- C. Complete KDADS Approved Skill Training requirements.
- D. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

**Frequency of Verification:**

- The MCOs, with oversight by KDADS, shall verify provider qualifications annually.
K.S.A. 65-5001 et seq.

Certificate (specify):

K.S.A. 65-5115
K.A.R. 28-51-113

Other Standard (specify):

Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO.

a. Must have a High School Diploma or equivalent or be at least eighteen years of age or older;

b. Complete KDADS Approved Skill Training requirements.

c. Must reside outside of waiver recipient's home;

d. Complete any additional skill training needed in order care for the waiver participant as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:
Service Definition (Scope):

Category 1: 12 Services Supporting Self-Direction

Sub-Category 1: 12010 financial management services in support of self-direction

Category 2: 12 Services Supporting Self-Direction

Sub-Category 2: 12020 information and assistance in support of self-direction

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:
Financial Management Services (FMS) is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model.

Services in support of participant direction are offered whenever a waiver affords participants the opportunity to direct some or all their waiver services. The participant is the sole employer of the direct service worker. The FMS provider is responsible for the provision of Information and Assistance tasks to assist the participant with understanding his or her role and responsibilities as the employer and his or her responsibilities under self-direction. The FMS Kansas Medical Assistance Program (KMAP) manual details the responsibilities of the FMS provider, waiver participant and the MCO.

FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant or legal guardian that the participant must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions including:
1. Verification and processing of time worked and the provision of quality assurance;
2. Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers’ compensation insurance requirements; making tax payments to appropriate tax authorities;
3. Performance of fiscal accounting and expenditure reporting to the participant or participant’s representative and the state, as required.
4. Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant’s representative in managing and directing services;
2. Assistance to the participant or participant’s representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct support workers (DSW), managing workers, and providing effective communication and problem-solving.

Payment for FMS
FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for DSWs. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service does not duplicate other waiver services. Where the possibility of duplicate provision of services exists, the participant’s Person-Centered Service Plan shall clearly delineate responsibilities for the performance of activities.
Access to this service is limited to participants who choose to self-direct some or all the service(s) when self-direction is offered.

FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E
× Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Enrolled Medicaid Provider of Financial Management Services</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

- Service Type: Supports for Participant Direction
- Service Name: Financial Management Services

Provider Category:
- Agency

Provider Type:
- Enrolled Medicaid Provider of Financial Management Services

Provider Qualifications

- License (specify):
  - Not applicable

- Certificate (specify):
  - Not applicable

- Other Standard (specify):
Enrolled FMS providers will furnish Financial Management Services according to the Kansas model. Organizations interested in providing Financial Management Services (FMS) are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment in KMAP to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually, and approval is subject to satisfactory completion of the required Generally Accepted Accounting Principles (GAAP) audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

For new organizations seeking to be a FMS provider, the FMS provider agreement and accompanying documentation are reviewed by KDADS and/or their designee to ensure that all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS, or designee.

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:
- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
- Including process for conducting background checks
- Process for establishing and tracking workers wage with the participant

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Services
HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14020 home and/or vehicle accessibility adaptations

Category 2: 

Sub-Category 2: 

Category 3: 

Sub-Category 3: 

Service Definition (Scope):

Category 4: 

Sub-Category 4: 

07/05/2023
In order to align this waiver service with federal requirements, the state will complete system changes to unbundle Assistive Services and submit a waiver amendment no later than 05/01/2021, in accordance with the timing agreed upon with CMS.

Assistive Services are those services which meet a participant’s assessed need by modifying or improving a participant’s home or otherwise enhancing the participant’s ability to live independently in his/her home and community through the use of adaptive equipment. For the purposes of this waiver, adaptive equipment includes durable medical equipment, van lifts and communication devices.

Adaptations or an improvement to the home that is of general utility and is not of direct medical or remedial benefit to the participant is excluded.

Reimbursement for this service is limited to the participant’s assessed level of service and based on the participant's Person-Centered Service Plan. All Assistive Services will be arranged by the MCO chosen by the participant, with the participant’s written authorization of the purchase. Participants will have complete access to choose from all qualified providers with consideration given to the most economical option available to meet the participant's assessed needs. If a related vendor, such as a Durable Medical Equipment provider, does not wish to contract with the MCO or FMS provider, the State shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

Assistive Services are subject to critical situation criteria. One of the three criteria listed below must be present for the MCO to authorize Assistive Services.

1. The Assistive Services purchase is critical to the participant’s ability to return to the community from the nursing facility and is a necessary expenditure within the first three months of the participant’s return to the community. Planning for the use of any Assistive Service shall occur prior to a person’s return to the community, when applicable. In all cases, the participant’s chosen KanCare managed care organization must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described situations.

2. Participant previously left waiver services for a Planned Brief Stay, and the Assistive Services request is critical to the participant’s ability to return to the community from the nursing facility or medical facility and is a necessary expenditure within the first three months of the participant’s return to the community. Planning for the use of any Assistive Service shall occur prior to a person’s return to the community, when applicable. In all cases, the participant's chosen KanCare managed care organization must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described situations.

3. There has been a DCF substantiation of one of the following situations:
   a. An Adult Protective Services investigation outcome of abuse, neglect or exploitation; or
   b. A Child Protective Services investigation outcome of abuse or neglect; or
   c. The participant is a recent victim of documented domestic violence.

All participants are held to the same criteria when qualifying for critical situation approval as in accordance with statewide policies and guidelines. Children under 21 years of must receive all medically necessary state plan services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services under the Physically Disabled Waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives.

Assistive Services are limited to the participant’s assessed level of service need, as specified in the participant’s Person-Centered Service Plan. There is a $7,500 maximum lifetime expenditure, across waivers with the exception of the I/DD Waiver. This limit was set based on the available waiver funds appropriated by the Kansas Legislature. The MCOs are required to provide services to meet participants health and safety needs. They have the option to authorize any services necessary for health and safety.

To avoid overlap of services, Assistive Service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort via the participant’s Person-Centered Service Plan.

• Purchase or rent of new or used assistive technology is limited to those items not covered under the State Plan.
• DME can only be accessed after a participant is no longer eligible for EPSDT services through the State Plan.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant.

The services under the Physically Disabled Waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- X Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Agency</td>
<td>Durable Medical Equipment provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:
| Individual |

Provider Type:
Durable Medical Equipment

Provider Qualifications
License (specify):
Not applicable
Certificate (specify):
Not applicable

**Other Standard (specify):**

Must affiliate or subcontract with a recognized Center for Independent Living or licensed home health agency (as defined in K.S.A. 65-5001 et seq.). Applicable work must be performed according to local and county codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

**Frequency of Verification:**

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

---

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Other Service

**Service Name:** Assistive Services

**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment provider

**Provider Qualifications**

**License (specify):**

- HHA: K.S.A. 65-5001 et seq.
- Pharmacy:
- Rural Health Clinic:

**Certificate (specify):**

HHA: K.S.A. 65-5115; K.A.R. 28-51-113

**Other Standard (specify):**
As described in K.A.R. 30-5-59
As described in K.S.A. 65-1626
Medicaid-enrolled provider
DME as a part of Assistive Services may be provided by all of the following:
  • Licensed Home Health Agency
  • Durable Medical Equipment provider
  • Pharmacy
  • Rural Health Clinic (medical supplies only)
  • Welding Shop (oxygen only)

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

A provider of services for a participant in foster care, adopted or part of KanBeHealthy may be excluded from the above requirements if a determination is made that a medically necessary piece of durable medical equipment can be cost-efficiently obtained only from a provider not otherwise eligible to be enrolled according to the current program guidelines.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

**Frequency of Verification:**
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

---

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Enhanced Care Service

**HCBS Taxonomy:**

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Sub-Category 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 Home-Based Services</td>
<td>08030 personal care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2</th>
<th>Sub-Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Service Definition (Scope): Enhanced Care Services provides non-nursing physical assistance and/or supervision during the participant’s normal sleeping hours in the participant’s place of residence. This assistance includes the following: physical assistance or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and prompting to take medication.

Providers will sleep and awaken as identified on the participant’s Person-Centered Service Plan and must provide the consumer with a mechanism to gain their attention or awaken them at any time (e.g., a bell or buzzer). Providers must be ready to call a physician, hospital, any identified contact individuals, or other medical personnel should an emergency arise. The scope of and intent behind Enhanced Care Services is entirely different from and therefore not duplicative of services defined as and provided under Personal Services.

Providers cannot live in the participant's home unless the provider qualifies for an exception, granted by the MCO, under the legally responsible exception.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Only one unit (a minimum of 6 hours) is allowed within a 24-hour period.
- ECS in combination with other HCBS services cannot exceed 24 hours within a 24-hour period.
- To avoid overlap of services, ECS is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- The participant’s Service Plan must document an assessed need for this service beyond what can be provided through Personal Emergency Response System (PERS) services.
- ECS must be provided in the participant’s home. Services providers must remain in the Participant’s home for the duration of this service provision in accordance with the Participant’s Service Plan.
- Participants residing in an institution, assisted living facility or residential setting or other type of group home are not eligible for ECS.
- ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest mitigated as ordered by the probate court or a designated representative is appointed to direct the care of the participant. Please see C-2-d, explaining that the guidelines for when legally responsible relatives can provide this service are described there.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:
Agency

Provider Type:
ECS provider

Provider Qualifications

License (specify):
Not applicable

Certificate (specify):
Not applicable

Other Standard (specify):
The agency must be a Medicaid enrolled provider, contracted and credentialed with Kancare MCO. The requirements pertaining to age and the ability to call the appropriate individual are for individual employees of the agency providing ECS, and the requirement to be an enrolled Medicaid provider pertains to the agency itself.

Verification of Provider Qualifications

Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Care Service

Provider Category:
Individual

Provider Type:
ECS provider

Provider Qualifications

License (specify):
Not applicable
Certificate (specify):

Not applicable

Other Standard (specify):

1. Be at least eighteen years of age; or
2. Must have a High School Diploma or equivalent;
3. Must have the ability to call appropriate individual/organization in case of an emergency and provide the intermittent care the individual may need
4. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider, acting as an administrative agent on behalf of the participant.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:

Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:

The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home-Delivered Meals Service

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>06 Home Delivered Meals</td>
<td>06010 home delivered meals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
</table>
Service Definition (Scope):
Category 4:                      Sub-Category 4:                      

Home-Delivered Meals service provides a participant with one (1) or two (2) meals per calendar date. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements which may not compromise a full nutritional regimen. The meals are prepared elsewhere and delivered to a participant's residence. Participants eligible for this service have been determined functionally in need of the Home-Delivered Meals service as indicated by the functional eligibility assessment and authorized in the Person-Centered Service Plan. Meal preparation by Physical Disability (PD) waiver Personal Care Services providers may be authorized in the Service Plan for those meals not provided under the Home-Delivered Meal service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to participants who require extensive routine physical support for meal preparation as supported by the participant's functional eligibility assessment.

This service may NOT be maintained when a participant is admitted to a nursing facility or acute care facility for a planned brief stay not to exceed two months following the admission month in accordance with Medicaid policy. This service is available in the participant's place of residence, excluding assisted living and Home Plus facilities.

To avoid overlap of services, Home Delivered Meals are limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

• This service may not duplicate home-delivered meals provided through the Older Americans Act
• This service is not duplicative of meal preparation provided by attendants through Personal Care Services.

No more than two (2) home-delivered meals will be authorized per participant for any given calendar date.

Service Delivery Method (check each that applies):

✓ Participant-directed as specified in Appendix E
✓ Provider managed

Specify whether the service may be provided by (check each that applies):

✓ Legally Responsible Person
✓ Relative
✓ Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Approved and Medicaid-enrolled nutrition provider agency</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Delivered Meals Service
Provider Category: Agency
Provider Type: Approved and Medicaid-enrolled nutrition provider agency

Provider Qualifications

License (specify):
Not applicable

Certificate (specify):
Not applicable

Other Standard (specify):

Provider must have on staff, or be contracted with, a certified dietician to assure compliance with KDADS nutrition requirements for programs under the Older Americans Act.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in KSA 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Medication Reminder Services

HCBS Taxonomy:

Category 1: 08 Home-Based Services
Sub-Category 1: 08030 personal care
Medication Reminder Services provides a scheduled reminder to a participant when it is time for the participant to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the providers system.

Medication Reminder/Dispenser is a device that houses a participant’s medication and dispenses the medication with an alarm at programmed times.

Medication Reminder/Dispenser Installation is the placement of the Medication Dispenser in a participant’s home.

Education and assistance with all Medication Reminder Services is made available to participants during implementation and on an ongoing basis by the provider of this service.

Medication Reminder Service is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Routine maintenance of rental equipment is the provider’s responsibility.
- Repair/replacement of rental equipment is not covered.
- Rental of equipment is covered.
- Purchase of equipment is not covered.

To avoid overlap of services, Medication Reminder is limited to those services not covered through EPSDT, the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant’s Person-Centered Service Plan. This service is not duplicative of services offered free of charge through any other agency or service.

These systems may be maintained on a monthly rental basis even if a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is available in the participant’s home. Medication Reminder service is not provided face-to-face with the exception of the Installation of Medication Reminder/Dispenser.

Installation of Medication Reminder/Dispenser is limited to one installation per participant per calendar year.

Service Delivery Method (check each that applies):

× Participant-directed as specified in Appendix E

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person
Relative
Legal Guardian

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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Services

Provider Category:
Agency

Provider Type:
Medication Reminder Services Provider/Dispenser Provider/ and Installation Provider

Provider Qualifications

License (specify):
Not applicable

Certificate (specify):
Not applicable

Other Standard (specify):
Any company providing medication reminder services per industry standards is eligible to contract with KanCare as a Medication Reminder Services.

Medication Reminder Service providers must provide appropriate training to their staff on medication administration and dispensing of medication.

All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System and Installation

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications
Sub-Category 1: 14010 personal emergency response system (PERS)

Category 2:  
Sub-Category 2:  

Category 3:  
Sub-Category 3:  

Category 4:  
Sub-Category 4:  

Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable participants at high risk of institutionalization to secure help in an emergency. The system is connected to the participant's telephone and programmed to signal a response center once the "help" button is activated. The participant may wear a portable "help" button to allow for mobility. PERS is limited to those individuals who:
1. Are alone for significant parts of the day, AND
2. Have no regular attendant (formal or informal) for extended periods of time, AND
3. Who would otherwise require extensive routine supervision.

The PERS system has a back-up battery that is activated if an emergency situation develops. The back-up battery will activate if there is interference with the landline and connection through the cell phone will remain as long as the cell phone towers are intact. If the system is not functioning properly, the provider will attempt to contact the participant through the PERS system. If unable to communicate with the participant, the provider contacts the participant-selected responders to contact with the participant in a 15-20-minute window. If the PERS provider is unable to reach the responders, then the provider will contact 911/EMS to check on the unresponsive participant. In addition, the PERS system should be checked once a month to ensure that it is functioning properly, and the back-up battery is functional. Participants have the ability to turn off/unplug the PERS system; however, turning off the system will trigger an alert to the PERS provider. The provider will follow up with the participant to ensure his/her health and welfare. The PERS provider must receive permission from the participant for the use of the device in the home.

PERS Installation is the placement of electronic PERS devices in a participant's residence. These participants have met the assessed need of a Personal Emergency Response System.

Personal Emergency Response System and Installation is an agency directed service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
To avoid any overlap of services, PERS is limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources. PD waiver funding is used as the funding source of last resort and requires prior authorization from the participant’s chosen KanCare MCO.

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of equipment is not covered.
- Rental of the PERS System is covered; purchase is not.
- Call lights do not meet this definition.
- Maximum of two PERS Installations per calendar year.
- PERS is based on the assessed need of the individual and authorized in the Person-Centered Service Plan.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>PERS and PERS Installation provider</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Personal Emergency Response System and Installation**

**Provider Category:**

- Agency

**Provider Type:**

- PERS and PERS Installation provider

**Provider Qualifications**

**License (specify):**

- Not applicable

**Certificate (specify):**

- Not applicable

**Other Standard (specify):**

-
Must be an enrolled Medicaid provider. Must conform to industry standards and any federal, state, and local laws and regulations that govern this service. The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel. All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.

Frequency of Verification:
The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):

- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.
- As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)
a. Criminal History and/or Background Investigations. Specify the state’s policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.
Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All HCBS providers shall perform background checks in accordance with the KDADS’ Background Check policy, and shall comply with all regulations related to Abuse, Neglect and Exploitation. All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding. Community Service Providers (CSPs) are responsible for ensuring background checks are completed on their employees and employees of persons or families for whom they perform administrative duties. CSPs may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, KDHE and KanCare MCO staff. Background checks are required of employees regardless of whether they are providing a licensed or non-licensed service. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process.

The employer shall submit a request for the following checks:
1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver’s license record check through the Kansas Department of Revenue (KDOR)
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ No. The state does not conduct abuse registry screening.
○ Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All HCBS providers shall perform background checks in accordance with the KDADS’ Background Check policy. All HCBS providers are required to pass DCF abuse registry checks consistent with the KDADS’ Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. All HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, KDHE and KanCare MCO staff. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings. All HCBS providers are required to pass ANE checks conducted by the following entities.
1. a check for ANE through the Nurse Aid Registry
2. an adult and child ANE check through Department of Children and Families (DCF)
Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reminder Services</td>
<td>×</td>
</tr>
<tr>
<td>Personal Emergency Response System and Installation</td>
<td>×</td>
</tr>
<tr>
<td>Home-Delivered Meals Service</td>
<td>×</td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td>×</td>
</tr>
<tr>
<td>Assistive Services</td>
<td>×</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>×</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>×</td>
</tr>
</tbody>
</table>

Facility Capacity Limit:

Six (6) or more

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (check each that applies):

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>×</td>
</tr>
<tr>
<td>Physical environment</td>
<td>×</td>
</tr>
<tr>
<td>Sanitation</td>
<td>×</td>
</tr>
<tr>
<td>Safety</td>
<td>×</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td>×</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>×</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>×</td>
</tr>
<tr>
<td>Resident rights</td>
<td>×</td>
</tr>
<tr>
<td>Medication administration</td>
<td>×</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>×</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>×</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>×</td>
</tr>
</tbody>
</table>
When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:
Home Plus

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reminder Services</td>
<td></td>
</tr>
<tr>
<td>Personal Emergency Response System and Installation</td>
<td></td>
</tr>
<tr>
<td>Home-Delivered Meals Service</td>
<td></td>
</tr>
<tr>
<td>Enhanced Care Service</td>
<td>✗</td>
</tr>
<tr>
<td>Assistive Services</td>
<td></td>
</tr>
<tr>
<td>Financial Management Services</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td></td>
</tr>
</tbody>
</table>

Facility Capacity Limit:

Not more than eight (8)

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (check each that applies):

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>✗</td>
</tr>
<tr>
<td>Physical environment</td>
<td>✗</td>
</tr>
<tr>
<td>Sanitation</td>
<td>✗</td>
</tr>
<tr>
<td>Safety</td>
<td>✗</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
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</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>✗</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>✗</td>
</tr>
</tbody>
</table>

07/05/2023
### Standard

| 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:

Not applicable

---

**Appendix C: Participant Services**

**C-2: General Service Specifications (3 of 3)**

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. Select one:

- **No.** The state does not make payment to legally responsible individuals for furnishing personal care or similar services.
- **Yes.** The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*
KDADS recognizes that families as Personal Care Services providers are an important part of our service delivery system.

A guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest is mitigated.

1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068.
   a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
   b. A copy of the special or annual report in which the conflict of interest is disclosed will be provided to the MCO and FMS provider if along with the judge’s order approving the annual or special report and determining that there is no conflict of interest for the guardian to be paid to provide supports for the participant under the HCBS program.

2. If the court determines that all potential conflict of interest concerns have not been mitigated, the legal guardian can:
   a. Select someone (family member or friend) to provide the HCBS services to the participant. If a family member or friend is not available, the participant’s selected MCO or FMS provider can assist the legal guardian in finding a direct support worker or seeking alternative HCBS service providers in the community, OR
   b. Select someone (family member, friend, non-paid guardian) to appoint as a Designated Representative to develop the integrated service plan and direct the participant’s services under HCBS.

3. An activated durable power of attorney (A DPOA who is currently authorized to make financial, medical or other decisions on behalf of the participant) is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual’s care (hire, fire, manage, training, and monitor direct support workers).

4. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available to the participant if the exception was not granted.

Legal guardians may be paid for providing PCS services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

The legal guardian or DPOA of an adult participant may provide, whenever the relative/legal guardian is qualified to provide Personal Care Service (PCS), self-directed (PCS) as specified in Appendix C-3.

**Self-directed**

**Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

- The state does not make payment to relatives/legal guardians for furnishing waiver services.
- The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.
The State of Kansas does not prevent non-legally responsible relatives from providing PCS and ECS services. The non-legally responsible relative is subject to the same requirements as detailed in the service definition and provider qualification in Appendix C.

The State of Kansas defines legally responsible individuals as:
1) the parent (biological or adoptive) of a minor child;
2) a spouse of a waiver participant;
3) the legal guardian or activated DPOA of a waiver participant;
4) a foster parent.

KDADS allows legally responsible individuals to provide PCS or ECS under the following circumstances:
1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflicts of interest have been mitigated in accordance with K.S.A. 59-3068.
   a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
   b. It shall be the responsibility for the legal guardian to provide to the MCO and FMS provider a copy of the special or annual report in which the conflict of interest is disclosed and a copy of the judge’s order or approval determining that there is no conflict of interest for the guardian to be paid to provide HCBS supports for the participant.
2. If the court determines that all potential conflicts of interest have not been mitigated; or the legal guardian otherwise chooses to provide personal care services, the legal guardian shall select a designated representative, who is not a legally responsible individual for the participant, to develop the Person-Centered Service Plan and direct the participant’s HCBS services.
3. An A-DPOA, who is currently authorized to make financial, medical or other decisions on behalf of the participant, is not permitted to be a paid provider unless a designated representative is appointed to direct the individual’s care.
4. The MCO may grant an exception to the above listed criteria when one of the three circumstances is present:
   1) The participant lives in a rural area, in which access to a provider is beyond a 50 mile radius from the participant's residence and the relative or family member is the only provider available to meet the needs of the participant.
   2) The participant lives alone and has a severe cognitive impairment, physical disability or intellectual disability
   3) The participant has exhausted other support options offered by the MCO and absent ECS would be at significant risk of institutionalization.

The controls that are employed to ensure that payments are made only for services rendered include: MCO quarterly Quality Reviews to monitor that services that are provided are approved in the Person-Centered Service plan, monitoring of PCS or ECS services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.

Specify:

- 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:
Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number/percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services

N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc. prior to furnishing waiver services

D=Number of all new licensed/certified providers

Data Source (Select one):

Other

If ‘Other’ is selected, specify:

Managed Care Organization (MCO) reports and record reviews

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**Performance Measure:**
Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards

\[ N = \text{Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards} \]

\[ D = \text{Number of enrolled licensed/certified waiver providers} \]

**Data Source** *(Select one):*
- Other
  - If 'Other' is selected, specify:
    - Managed Care Organization (MCO) reports and record reviews

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### b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services

\[
N = \text{Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services} \\
D = \text{Number of all new non-licensed/non-certified providers}
\]

**Data Source** (Select one):
Other
If ‘Other’ is selected, specify:
Managed Care Organization (MCO) reports and record reviews

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Performance Measure:
Number and percent of non-licensed/non-certified waiver providers that continue to meet waiver requirements

- \( N \) = Number of non-licensed/non-certified waiver providers that continue to meet waiver requirements
- \( D \) = Number of non-licensed/non-certified waiver provider

Data Source (Select one):
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If ‘Other’ is selected, specify:
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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.

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.
Performance Measure:
Number and percent of active providers that meet training requirements

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in the HCBS quality strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

### b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff request, approve, and assure implementation of corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through the quality review process. These processes are monitored by both program managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the HCBS quality strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

**Remediation-related Data Aggregation and Analysis (including trend identification)**

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07/05/2023
c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (select one).

- Not applicable - The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (check each that applies)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.
Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCBS 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 HCBS 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 HCBS Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State has proposed a Statewide Transition Plan for residential and non-residential settings to comply with federal HCBS setting requirements, pending approval from CMS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Person Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):

   Registered nurse, licensed to practice in the state
   Licensed practical or vocational nurse, acting within the scope of practice under state law
   Licensed physician (M.D. or D.O)
Case Manager (qualifications specified in Appendix C-1/C-3)
Case Manager (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Social Worker
Specify qualifications:

× Other
Specify the individuals and their qualifications:

Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community Based Services (HCBS) services as one part of the comprehensive KanCare program. The MCOs are responsible for development of the Person-Centered Service Plan (Service Plan) in accordance with KDADS’ Person-centered Service Plan policy. The MCO or their designee will use their staff to provide this service.

Appendix D: Participant-Centered Planning and Service Delivery
D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Select one:

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

Appendix D: Participant-Centered Planning and Service Delivery
D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant’s authority to determine who is included in the process.
MCOs and providers follow the processes outlined in the KDADS’ Person-Centered Service Plan policy to provide the individual with the maximum amount of opportunity to direct and be actively engaged in the person-centered planning process.

Each participant found eligible for PD waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that are available to the participant. The participant, MCO, or the MCO's designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant’s chosen provider.

The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
The Person-Centered Service Plan process and expectations are outlined in the KDADS’ Person-Centered Service Plan policy.

a) MCOs may use contracted entities to assist in the development and monitoring of the Person-Centered Service Plan (Service Plan) but has primary responsibility for Service Plan development and accountability to deliver all Medicaid covered services included in a participant’s Service Plan. The initial and annual Service Plans are developed during a face-to-face meeting with the participant, legal representative (if applicable), the MCO and selected representatives that the participant chooses to be involved. The date and time of the Service Plan meeting is coordinated based on the convenience of the participant and the participant’s representative, if applicable. The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The KDADS’ Person-Centered Service Plan policy outlines who the required participants are in the development of the Service Plan. MCOs, or their designee, are required to invite known HCBS providers for the individual to the Service Plan meeting unless otherwise specified by the individual. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting. If the participant has a court-appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on the Service Plan.

The Service Plan is valid for 365 days from the date of the participant’s and/or legal representative’s signature unless there is a change in condition that requires an update to the Service Plan as detailed in the Person-Centered Service Plan policy.

b) All applicants for program services must undergo a functional eligibility assessment to determine functional eligibility for the PD waiver. The FEI is utilized to determine the level of care (LOC) eligibility for the PD waiver. The state’s functional eligibility contractor conducts an assessment of the individual within the timeframe specified in the contract, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant within six months and must address physical, behavioral and functional needs in the Person-Centered Service Plan that identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle.

The participant will complete a Participant Interest Inventory (PII). The PII is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Service Plan meeting and will use the PII to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

c) Each participant found eligible for PD waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that is available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant’s chosen provider.

d) Through the various assessments and Service Plan related documents described in b) above, the participant’s goals, needs, and preferences are at the forefront of developing their Service Plan. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.

e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS’ Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, upon MCO notification or awareness of necessitating circumstances. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature
and severity of the participant's disability. Additional meetings may be necessary due to changes in conditions or circumstances.

f) The responsibilities for implementing and monitoring the delivery of services as authorized in the Service Plan are detailed in the Person-Centered Service Plan policy and the HCBS Quality Review Policy. MCOs shall conduct one face-to-face or telephonic visit with the participant within 30 days of transitions from any alternate setting of care, after which the MCO must follow up with quarterly telephone calls and face-to-face visits every six months.

g) The requirements for how and when the Service Plan are updated are specified in the KDADS’ Person-Centered Service Plan policy. The MCOs conduct periodic reviews, as specified by the KanCare MCO contracts, to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in conditions or circumstances. Additional Person-Centered Service Plan meetings may be necessary due to changes in conditions or circumstances that require updates to the participant’s plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant’s wishes and needs:

1) Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability;
2) Change in behaviors that may lead to loss of foster placement or removal from the home;
3) Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan;
4) Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater;
5) Upon the request of any waiver participant, guardian or legal representative;
6) Any health and/or safety concern;
7) Any change in needs for an HCBS recipient not listed above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.
The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument and the MCO needs assessment which identifies potential risk factors. The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers. The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met. The Participant Interest Inventory (PII), a document that is a part of the Service Plan, describes, in the participant's own words, how the participant would like their supports to be provided. This includes any interventions that are identified as necessary to mitigate risk to the participant's health safety and welfare (PII Risk Assessment & Intervention Plans).

Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the Person-Centered Service Plan policy.

A back-up plan for each individual is established during the needs assessment and Person-Centered Service Plan development. This and other information from the assessment and annual re-assessment are incorporated into a backup plan which is utilized to mitigate risk related to extraordinary circumstances. Backup plans are developed according to the unique needs such as physical limitations and circumstances, such as the availability of informal supports of each participant. Backup arrangements are added to Service Plans and identify key elements, including specific strategies and contact individuals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The State assures that each participant will be given free choice of all qualified providers of each service included in his/her written Person-Centered Service Plan. The MCO provides each eligible participant with a list of providers from which the participant can choose a service provider. The MCO assists the participant with accessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers for waiver services identified in their Person-Centered Service Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

KDADS conducts quarterly reviews of the MCOs to ensure that the performance measures outlined in the waiver application are met. As part of the review, the initial, annual and current Person-Centered Service Plan are reviewed to insure compliance with performance standards. KDADS reports to KDHE on the findings of the audits during the quarterly audit meetings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:
Every three months or more frequently when necessary
Every six months or more frequently when necessary
Every twelve months or more frequently when necessary
Other schedule

Specify the other schedule:

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i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Service plans and related documentation will be maintained by the consumer’s chosen KanCare MCO, and will be retained at least as long as this requirement specifies.

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Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.
The MCOs are responsible for monitoring the implementation of the Person-Centered Service Plan and for ensuring the health and welfare of the participant with input from the PD Program Manager and KDADS Regional Field Staff. Service Plan implementation is assessed through the comprehensive statewide KanCare Quality Improvement Strategy (which includes all of the HCBS waiver performance measures). Kansas also monitors the Adverse Incident Reporting system and implements corrective action plans for remediation with the MCOs.

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether to self-direct their services;
- Services meet participant’s needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant’s health and safety are assured, to the extent possible; and
- Participants have access to Medicaid State Plan services when the participant's need for services has been assessed and determined medically necessary.

Individual monitoring by the MCOs is defined as:

- Face-to-face meetings will occur in accordance with the Person-Centered Service Plan policy.
- Face-to-face meetings between MCO and participant are required every six months to evaluate the participant’s ongoing needs.
- Face-to-face meetings are expected if the participant has a significant change in needs, eligibility, or preferences that will modify the participant’s current Person-Centered Service Plan.
- Contact with the participant on a monthly basis is required if the participant’s health and welfare needs are at risk of significant decline or the participant is in imminent risk of death or institutionalization.

Face-to-face meetings are expected if the participant has a significant change in needs, eligibility, or preferences that will modify the participant’s current Person-Centered Service Plan.

In addition, the Person-Centered Service Plan and choice are monitored by state quality review staff as a component of waiver assurance and minimum standards. Any issues in need of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation and reported to the PD Program Manager.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. The HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency are part of this strategy.

State staff request, approve, and ensure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:
Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record reviews

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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

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Data Aggregation and Analysis:
Performance Measure:
Number and percent of waiver participants whose service plans address health and safety risk factors

\[ N = \text{Number of waiver participants whose service plans address health and safety risk factors} \]
\[ D = \text{Number of waiver participants whose service plans were reviewed.} \]

Data Source (Select one):
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If 'Other' is selected, specify:

Record reviews

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b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures
For each performance measure, the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver

\[N = \text{Number of waiver participants}\]

\[D = \text{Number of waiver participants whose service plans were reviewed}\]

**Data Source** (Select one):
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Performance Measure:
Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan

\[ N = \text{Number of waiver participants (or their representatives)} \]

\[ D = \text{Number of waiver participants whose service plans were reviewed} \]

Data Source (Select one):
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### c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.
Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant’s annual redetermination date D=Number of waiver participants whose service plans were reviewed

**Data Source (Select one):**
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KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency

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Performance Measure:
Number and percent of waiver participants with a documented change in needs whose service plan was revised, as needed, to address the change

\[
N = \text{Number of waiver participants with a documented change in needs whose service plan was revised, as needed, to address the change}
\]

\[
D = \text{Number of waiver participants whose service plans were reviewed.}
\]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record Review

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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

\[ \text{N} = \text{Number of survey respondents who reported receiving all services as specified in their service plan} \]
\[ \text{D} = \text{Number of waiver participants interviewed by the QMS (Quality Management staff)} \]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Customer interviews, on-site

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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**

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</table>
| Sub-State Entity | × Quarterly | × Representative Sample  
Confidence Interval = 95% +/-5% |
| × Other  
Specify: KanCare Managed Care Organizations (MCOs) | Annually | × Stratified  
Describe Group: Proportionate by MCO |
| | Continuously and Ongoing | Other  
Specify: |
| Other  
Specify: | | |

**Data Aggregation and Analysis:**

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Specify: | × Annually |
Responsible Party for 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

Frequency of data aggregation and analysis (check each that applies):

- Continuously and Ongoing

Other
Specify:

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```
e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care

\[
N = \text{Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care}
\]

\[
D = \text{Number of waiver participants whose files are reviewed for the documentation.}
\]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record reviews

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### Sample Confidence Interval

95% +/- 5%

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Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services

\[ N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver services} \]
\[ D = \text{Number of waiver participants whose files are reviewed for the documentation} \]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

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- **Other**
  - Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency

- **Other**
  - Specify: Annually

- **Other**
  - Specify: Continuously and Ongoing

### Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services vs. an institutional alternative

\[
\frac{N}{D} = \frac{\text{Number of waiver participants whose record contains documentation indicating a choice of community-based services}}{\text{Number of waiver participants whose files are reviewed for the documentation}}
\]

### Data Source (Select one):

- **Other**
  - If ‘Other’ is selected, specify: Record reviews

### Responsible Party for data collection/generation (check each that applies):

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- **Confidence Interval** = 95% +/- 5%
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**Performance Measure:**

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers
D=Number of waiver participants whose files are reviewed for the documentation.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

Record review

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring. Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation
   Remediation-related Data Aggregation and Analysis (including trend identification)

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c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The state requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.
a) All participants of PD waiver services have the opportunity to choose the KanCare managed care organization that will support them in overall service access and care management. The opportunity for participant direction (self-direction) of Personal Services and Enhanced Care Services is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100).

This opportunity includes specific responsibilities required of the participant, including:
1. Recruitment and selection of Personal Care Service (PCS) worker, back-up PCS and Enhanced Care Services Financial Management Service (FMS) providers;
2. Assignment of service provider hours within the limits of the authorized services;
3. Complete an agreement with an enrolled Financial Management Services (FMS) provider;
4. Referral of providers to the participant's chosen FMS provider;
5. Provider orientation and training;
6. Maintenance of continuous service coverage in accordance with the Person-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
7. Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
8. Other monitoring of services; and
9. Dismissal of the worker, if necessary.

b) Participants are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant’s Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant’s Person-Centered Service Plan. The MCO supports the participant who selects self-direction of services by monitoring services to ensure that they are provided by Personal Care Attendants and Enhanced Care Services attendants in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider. FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant’s representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:
• Verification and processing of time worked and the provision of quality assurance;
• Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers’ compensation insurance requirements; making tax payments to appropriate tax authorities;
• Performance of fiscal accounting and expenditure reporting to the participant or participant’s representative and the state, as required.
• Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:
1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant’s representative in managing and directing services;
2. Assistance to the participant or participant’s representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing.
identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. Select one:

- **Participant: Employer Authority.** As specified in Appendix E-2, Item a, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

- **Participant: Budget Authority.** As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

- Participants 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.
Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction option is available for Personal Care Services and Enhanced Care Services.

Participant-direction is offered for the following services:

Enhanced Care Services
Financial Management Services
Assistive Services- Home Modifications
Personal Care Services

Self-direction is not an option when the participant/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be documented by the MCO and is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Participants are informed that, when choosing participant direction (self-direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self-direct services:

- the limitation to Personal Services and Enhanced Care Services;
- the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
- related responsibilities (outlined in E-1-a);
- potential liabilities related to the non-fulfillment of responsibilities in self-direction;
- supports provided by the managed care organization (MCO) they have selected;
- the requirements of personal care attendants;
- the ability of the participant to choose not to self-direct services at any time; and
- other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency- directed services.

b) The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chosen this option and identified an enrolled provider. This information is available from the PD Program Manager, KDADS Regional Field Staff, and the PD KMAP Manual.

a) Information regarding self-directed services is initially provided by the MCO during the Person-Centered Service Plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's Person-Centered Service Plan. This information is reviewed at least annually with the member. The option to end self-direction can be discussed, and the decision to choose agency-directed services can be made at any time.
f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (select one):

- The state does not provide for the direction of waiver services by a representative.
- The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (check each that applies):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

To ensure that non-legal representatives’ function in the best interests of the participant, additional safeguards are in place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self-direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the participant's case file, certain situations arise, particularly when the participant's health and welfare needs are not being met. In addition, post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS Quality Management Specialist and/or MCO staff serve to monitor participant services and serve as safeguards to ensure the participant's best interests are followed. Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Participant-direction by a representative is subject to 42 CFR 441.301(1)(vi) and in accordance with D-1-b.

In the event that a non-legal representative has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the individualized plan of care. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest available on the KDADS website: www.kdads.ks.gov/docs/default-source/CSP/HCBS/HCBS-Policies/kansas-hcbs-conflict-of-interest-policy---6-15-15.pdf?sfvrsn=2
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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Care Service</td>
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<td></td>
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<tr>
<td>Assistive Services</td>
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<tr>
<td>Financial Management Services</td>
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<td>Personal Care Services</td>
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</tr>
</tbody>
</table>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one:

- Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).
  - Specify whether governmental and/or private entities furnish these services. Check each that applies:
    - Governmental entities
    - Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. Select one:

- FMS are covered as the waiver service specified in Appendix C-1/C-3

  The waiver service entitled:
  - Financial Management Services

- FMS are provided as an administrative activity.

Provide the following information

- i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:
Enrolled FMS providers furnish Financial Management Services using the Employer Authority provider model. Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are reimbursed a monthly fee per participant through MMIS. The per member per month payment is based on a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FFS rate.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (check each that applies):

Supports furnished when the participant is the employer of direct support workers:

- [x] Assist participant in verifying support worker citizenship status
- [x] Collect and process timesheets of support workers
- [x] Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

*Specify:*

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant’s participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

*Specify:*
iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) The State assess the performance of the FMS providers through the annual GAAP audit reports, performed by an independent CPA, submitted to KDADS. In addition, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit KDHE or KDADS, their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59). KDADS monitors and verifies accurate tracking of service provided by self-directed providers and paid out through the FMS providers via the Electronic Visit Verification system and accompanying suite of reports. State and MCO staff work together to address/remediate any issue identified in accordance with the KDADS Financial Management Service policy. FMS providers contract with the MCOs to support KanCare members and are included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

(b) KDADS is responsible for the monitoring that occurs through the EVV system. The MCOs are accountable to ensure the FMS providers comply with their contract and State policy which outlines the requirements for annual GAAP audits. KDADS accepts the remittance for unused funds from the FMS providers and remits the federal portion to KDHE for disbursement back to Medicaid.

(c) The MCOs verify that FMS providers meet provider qualification requirements in the HCBS waivers in accordance with the KDADS Provider Qualifications policy. The FMS providers are responsible for obtaining a GAAP audit each year. The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ state wide single audit each year.

Appendix E: Participant Direction of Services
E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their
services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

- **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reminder Services</td>
<td>✗</td>
</tr>
<tr>
<td>Personal Emergency Response System and Installation</td>
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</tr>
<tr>
<td>Home-Delivered Meals Service</td>
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</tr>
<tr>
<td>Enhanced Care Service</td>
<td>✗</td>
</tr>
<tr>
<td>Assistive Services</td>
<td></td>
</tr>
<tr>
<td>Financial Management Services</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td></td>
</tr>
</tbody>
</table>

- **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

**Appendix E: Participant Direction of Services**

**E-1: Overview (10 of 13)**

**k. Independent Advocacy (select one).**

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:
Participants may access independent advocacy through the local Department for Children and Families, Aging & Disability Resource Center, MCO Care Coordinator or by directly contacting the Disability Rights Resource Center (DRC).

The Disability Rights Center of Kansas is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC operates eight federally authorized and funded protection and advocacy programs in Kansas. Participants are referred directly to DRC from various sources including KDADS.

Various community and disability organizations such as the Cerebral Palsy Research Foundation offer independent advocacy for Kansas participants.

Appendix E: Participant Direction of Services
E-1: Overview (11 of 13)

1. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

One of the participant's opportunities, as well as responsibilities, is the ability to discontinue self-direction. At any time, if the participant chooses to discontinue self-direction, he/she is to:

- Notify all providers as well as the Financial Management Services (FMS) provider.
- Maintain continuous attendant coverage for authorized Personal Care Services and/or Enhanced Care Services.
- Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the participant, to allow for the coordination of service provision.

The duties of the participant's KanCare MCO include:
- Explore other service options and complete a new Participant Choice form with the participant; and
- Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources
- Work with the participant to maintain continuous coverage as outlined and authorized in the participant's Service Plan.
- The MCO, though their care management and monitoring activities, works with the participant's self-directed provider to assure participant health and welfare during the transition period.
- Ensure open communication with both the participant and the self-directed provider, monitor the services provided, and gather continual input from the participant as to satisfaction with their services.

Appendix E: Participant Direction of Services
E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.
The participant's chosen KanCare MCO or the KDADS may discontinue self-direction and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:

1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if the health and welfare needs of the participant are not met as observed by the MCO or confirmed by the Kansas Department of Children and Families (DCF) Adult Protective Services (APS);
3. if the direct support worker has not adequately performed the services as outlined in the Peron-Centered Service Plan (Service Plan);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or service provider has abused or misused self-direction including:
   a. the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the needs assessment and/or POC;
   b. the participant/representative has directed the service providers to provide, and the service providers has in fact provided paid comprehensive support or Enhanced Care Services beyond the scope of the service definition;
   c. the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the Service Plan;
   d. the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the service providers for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:

1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participants attending physician or RN no longer authorizes the participant to self-direct his/her care; or
3. the participant/representative has committed a fraudulent act.

A timely Notice of Action (NOA) shall be sent to the participant prior to the effective date for termination of the participant's participation in the Self-Directed Care Option. The MCO coordinates to ensure there is not a lapse in service delivery.

The MCO works with the participant to maintain continuous attendant coverage as outlined and authorized on the participant's Service Plan. The MCO, though their care management and monitoring activities, works with the participant's choice of a non-self-directed agency to assure participant health and welfare during the transition period and beyond by communicating with both the participant and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the participant as to satisfaction with services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Employer Authority Only</th>
<th>Budget Authority Only or Budget Authority in Combination with Employer Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>6472</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>6472</td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td>Year 5</td>
<td>6472</td>
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</tr>
</tbody>
</table>
Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. Select one or both:

- **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

  Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Select one or more decision making authorities that participants exercise:

- **Recruit staff**
- **Refer staff to agency for hiring (co-employer)**
- **Select staff from worker registry**
- **Hire staff common law employer**
- **Verify staff qualifications**
- **Obtain criminal history and/or background investigation of staff**

  Specify how the costs of such investigations are compensated:

  The direct service worker (provider) covers the cost of the criminal history and/or background investigation of staff should the participant request one.

  Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

  Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

  All HCBS providers are required to pass background checks consistent with the KDADS’ Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

  **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
  **Determine staff wages and benefits subject to state limits**
  **Schedule staff**
Orient and instruct staff in duties
Supervise staff
Evaluate staff performance
Verify time worked by staff and approve time sheets
Discharge staff (common law employer)
Discharge staff from providing services (co-employer)
Other
Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Select one or more:

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the state's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.
ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services
E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services
E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services
E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:
Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.
Request for Fair Hearing Regarding a Functional Eligibility Determination:

Kansas has contracted with independent assessors to conduct level of care determinations (functional eligibility). Decisions made by the independent assessors are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors with their decision on the LOC determination/redetermination.

Applicants/beneficiaries may file only a fair hearing for an adverse decision by MCO:

KanCare Managed Care Organizations (MCOs) are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member.

Each participant is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. Participant grievance processes and Fair Hearing processes can also be found at the KanCare website.

KanCare participants have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 calendar days of receipt, and written response to the grievance will be given to the participant within 30 calendar days (except in cases where it is in the best interest of the member that the resolution timeframe be extended). If the MCO fails to send a grievance notice within the required timeframe, the participant is deemed to have exhausted the MCO’s appeal process, and the participant may initiate a State Fair Hearing.

An appeal can only occur under the following circumstances:

- If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
- Members will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: Members or (a friend, an attorney, or anyone else on the member’s behalf can file an appeal).
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 60 days calendar days plus 3 calendar days after the participant has received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant’s appeal will be resolve in 45 calendar days.

Fair Hearings

A member may request a Fair Hearing upon receiving a Notice of Action.

A Fair Hearing is a formal meeting where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all the facts and then hears motions, conduct hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge.

If the participant is not satisfied with the decision made on the appeal, the participant or their representative may ask for a fair hearing. The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision.

The request be submitted in writing and mailed or faxed to:
Office of Administrative Hearings 1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

Participants have the right to benefits continuation of previously authorized services while a hearing is pending and can request such benefits as a part of their fair hearing request. All three MCOs will advise participants of their right to a State Fair Hearing. Participants have to finish their appeal with the MCO before requesting a State Fair hearing.

For all KanCare MCOs:
In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs’ member web site. In addition, every notice
of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

The State requires that all MCOs define an “action” pursuant to the KanCare contract and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event their Medicaid application is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

MCOs retain all Notices of Action in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one:

- No. This Appendix does not apply
- Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. Select one:

- No. This Appendix does not apply
- Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:
Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. Participants have the right to submit grievances or appeals to their assigned managed care organization. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), requires the managed care organizations to operate a member grievance and appeal system consistent with federal regulations and Attachment D of the State’s contract with CMS. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1. KanCare members are informed that filing an appeal with the MCO is a prerequisite for a Fair Hearing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are part of the State’s fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State’s fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. The fiscal agent team escalates any grievance prior to the 3-occurrence timeframe based on the severity of the grievance. Through the escalation processes the fiscal agent team contacts KDADS, KDHE or the appropriate local authority who have access to this information at any time to ensure the member’s safety and wellbeing.

Complaints are received in the DXC Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately. Grievance Unit must make contact related to a grievance within 3 business days. If the situation is urgent, the grievance staff make contact immediately. The grievance is required to be resolved within 30 calendar days.

As part of its regulatory role to educate consumers regarding their rights and responsibilities, CDDOs educate consumers regarding their due process rights including the complaint/grievance process and the fair hearing process. DDRA and implementing regulations available to submit to CMS upon request.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or
Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. Select one:

- Yes. The state operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
- No. This Appendix does not apply (do not complete Items b through e)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Definitions of Kansas Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 39, Article 14 for adults:

K.S.A. 39-1430. Abuse, Neglect or Exploitation of certain adults:

K.S.A. 39-1430(b): Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a waiver participant, including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult; 4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician’s orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5) a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6) Fiduciary Abuse; or 7) omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

K.S.A. 39-1430(c): Neglect: The failure or omission by one’s self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

K.S.A. 39-1430(d): Exploitation: Misappropriation of an adult’s property or intentionally taking unfair advantage of an adult’s physical or financial resources for another individual’s personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

K.S.A. 39-1430(e): Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person’s trust or benefit.

Department for Children and Families (DCF) reportable events as described in Kansas Statute Chapter 38, Article 22 for children:

Neglect - K.S.A. 38-2202(t): Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child’s parents or other custodian. Neglect may include, but shall not be limited to:
-o (1) Failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child;
-o (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
-o (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:
-o (1) Be photographed, filmed or depicted in pornographic material; or
-o (2) be subjected to aggravated human trafficking, as defined in K.S.A. 2018 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another, or be subjected to an act which would constitute conduct proscribed by article 55 of chapter 21 of the Kansas Statutes Annotated or K.S.A. 2018 Supp. 21-6419 or 21-6422, and amendments thereto.

Abandonment - K.S.A 38-2202 (a): To forsake, desert or, without making appropriate provision for the substitute care,
cease providing care for the child.

Fiduciary Abuse - K.S.A. 39-1430(e): A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person’s trust or benefit

All DCF reportable events including Abuse, Neglect, Exploitation, and Fiduciary Abuse are required to be reported to the Kansas Department for Children and Families and once a determination has been made by DCF, the event must be entered into the Adverse Incident Reporting (AIR) system by KDADS if the event has not yet been entered by DCF staff in accordance with KDADS HCBS Adverse Incident Monitoring Standard Operating Procedure (SOP).

Reporting KDADS defined adverse incident requirements:

Other adverse incidents to be reported by KDADS staff into AIRS include, Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusion, and Restrictive interventions. See KDADS HCBS Adverse Incident Reporting and Management policy 2017-110 for definitions of all adverse incidents that are required to be reported by KDADS staff.

Additionally, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110. These acts include all use of restraints, seclusion and restrictive intervention.

Identification of the individuals/entities that must report critical events and incidents:

The Kansas statutes K.S.A. 39-1431 and K.S.A. 38-2223 identify mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult or minor immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychiatric aide, 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 officer of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Specifically, mandated reporters include: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF) and Substance Abuse Treatment Facilities. All other individuals who may witness a reportable event may voluntarily report it.

The timeframes within which critical incidents must be reported:

The timeframes within which critical incidents must be reported: KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days, of receiving the information. Outside of working hours, the reports shall be submitted to DCF on the first working day that the Kansas Department for Children and
Families is in operation after the receipt of such information.

All reports of suspected Abuse, Neglect, Exploitation, and Fiduciary Abuse must be reported to the Kansas Department for Children and Families promptly and in accordance with K.S.A. 39-1431 for adults and K.S.A. 38-2223 for children. All other adverse incidents as defined by KDADS in this section and as defined in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 must be reported directly into the AIR system no later than 24 hours of becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110.

The method of reporting:

Reports shall be made to the Kansas Department for Children and Families during the normal working week days and hours of operation. Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330 or online at http://www.dcf.ks.gov/Pages/Report-Abuse-or-Neglect.aspx. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911. All reports directed to DCF will be uploaded into the web-based Adverse Incident Reporting system (AIR).

Kansas Department for Children and Families reportable incidents and all KDADS defined adverse incidents must be reported directly into AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP. These include, in addition to suspected incidents of Abuse, Neglect, Exploitation or Fiduciary Abuse: Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Restraint, Seclusion, E/R visit, Hospitalization, Misuse of Medications, Natural Disaster, Serious Injury, Suicide, Suicide Attempt. See KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110 for definitions of KDADS reportable adverse incidents. Also, the reporter can select as many adverse incidents as may apply per that particular situation. Anyone who suspects a child or adult is experiencing any of the above types of DCF reportable events or KDADS adverse incidents may also report it through the DCF hotline.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant’s chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect, Exploitation or Fiduciary Abuse. Information and training on these subjects is provided by the MCOs to participants in the participant handbook, is available for review at any time on the MCO participant website, and is reviewed with each participant by the care management staff responsible for service plan development, and during the annual process of person-centered service plan development. Depending upon the individual needs of each participant, additional training or information is made available and related needs are addressed in the participant’s Person-Centered Service Plan. The information provided by the MCOs is consistent with the state’s Abuse, Neglect, Exploitation and Fiduciary Abuse incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of participant Abuse, Neglect, Exploitation and Fiduciary Abuse).

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.
• The entity that receives reports of each type of critical event or incident:

For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.

The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of the reporter becoming aware of the adverse incident by direct entry into the KDADS web-based AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP.

• The entity that is responsible for evaluating reports and how reports are evaluated:

All reports of Abuse, Neglect, Exploitation and Fiduciary Abuse are reported to and investigated by DCF. Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with, K.S.A. 38-2223 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS, which is entered into AIRS and reviewed by KDADS staff.

KDADS is the entity responsible for evaluating all adverse incident reports in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS HCBS Adverse Incident Monitoring SOP. All events reported to AIRS are reviewed by KDADS staff to determine whether or not they meet the SOP definition of an adverse incident. Those that do not are screened out from further investigation by KDADS. Those that meet the definition are investigated by KDADS and contracted MCOs. Any event reported through AIRS that involves the possible abuse, neglect, exploitation or fiduciary abuse of children that was not reported first to DCF is immediately reported to DCF by KDADS for further investigation.

In accordance with the KDADS HCBS Adverse Incidents Monitoring Standard Operating Procedure (SOP), KDADS Program Integrity and Compliance Specialists (PICS) or their designated back-up(s) are responsible for checking AIRS for any newly reported adverse incident. AIRS will automatically distribute adverse incident reports for review based on the issue, KDADS provider/program type (e.g., Behavioral Health, Older Americans Act, Senior Care Act, HCBS Waiver), and county location of the incident. If data was entered incorrectly, the KDADS PICS must correct any errors, and re-route the review to the appropriate KDADS party. This process will occur within one business day of receipt of an adverse incident report.

If AIRS does not auto assign the adverse incident, the KDADS PICS will review the adverse incident report and assign it appropriately within AIR. If the member requires protective services intervention or review, the PICS will immediately notify and forward the adverse incident report to (DCF) for further investigation.

If an Adverse Incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in each of the HCBS waivers. DCF must notify KDADS outlining DCF’s determination for the incident within five business days of the date of DCF determination, in accordance with the DCF Policy and Procedure Manual (Chapter 10320) and as defined in KSA 39-1433/38-2226.

For all submitted AIR reports, PICS first review AIRS adverse incident report information to determine if there is any indication of criminal activity and report any instances to law enforcement. If it is determined that there is suspected for Abuse, Neglect, Exploitation or Fiduciary Abuse, the KDADS PICS report immediately to DCF. Any areas of vulnerability would be identified for Additional training and assurance of education. PICS determine if the adverse incident report is screened in, screened out, or requires additional follow-up. Even for those incidents referred to DCF,
PICS document the incident and notify the participant’s MCO of the incident.

Within one business day of receiving an AIR report, KDADS PICS will determine the level of severity for each screened in adverse incident reported in AIRS, and will assign a level of severity. Within one business day of a determination of the severity level PICS will notify the participant’s MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up. KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member’s Person-Centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP.

• The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. Per PPS policy number 1521, reports assigned for Abuse/Neglect concerns shall be assigned with either a same day or 72-hour response time. Reports assigned as Non-Abuse/Neglect Family in Need of Assessment (NAN FINA) are assigned a response time per PPS policy number 1670.

PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. KDADS assigns the report to the participant’s managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

• The entity that is responsible for conducting investigations and how investigations are conducted:

DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

Review and Follow-up for Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children.

1. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF, if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services.

2. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS.

3. The report will not be assigned for further assessment or may be screened out after acceptance if the following apply:
   a. The report does not meet the criteria for further assessment per DCF PPS Policy and Procedure Manual;
   b. The event has previously been investigated;
   c. DCF does not have the statutory authority to investigate;
   d. Unable to locate family.

4. Not all reportable events require remediation; DCF shall determine which reportable events will result in remediation.
The process and timeframes for informing the participant (or the participant’s family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results includes:

Notice of Department Finding per DCF PPS Policy Number 2540:
The Notice of Department Finding for reports is PPS 2012. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.

All case decisions/findings shall be staffed with the CPS Supervisor/designee and a finding shall be made within thirty (30) working days of receiving the report. DCF sends the Notice of Department Finding to relevant persons who have a need to know of the outcome of an investigation of child abuse/neglect on the same day, or the next business day, of the case finding decision.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.
- The state entity or entities responsible for overseeing the operation of the incident management system:

Kansas Department for Children and Families (DCF) is responsible for overseeing the reporting of and response to all reportable events related to Abuse, Neglect, Exploitation and Fiduciary Abuse. DCF maintains a database of all reportable events and transfers pertinent information from the database to AIRS.

KDADS is the entity responsible for overseeing the operation of the web-based adverse incident management system called AIRS, and responding to incidents reported in AIRS.

- The methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

The KDADS Program Integrity Manager will, on a monthly basis, provide an AIR System Reconciliation Report to DCF-APS and CPS, which includes the number of all incidents KDADS received from each entity in the reported month. The purpose of this report is to verify all incidents reported to DCF-APS and CPS that require KDADS review were subsequently provided to KDADS. KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

The KDADS Program Quality Management Specialists review statewide trend analysis from AIR system aggregate-level reports across all MCOs and determine how the overall number of adverse incidents compares to previous reports. For each MCO, and across all MCOs, the Program QMS Program Manager will determine if there is a pattern in the number and percentage of adverse incidents and the potential driving forces. Based on these trends, favorable outcomes will be promoted and trends with the potential to negatively impact the program or members will be remediated. KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

- The frequency of oversight activities:

In accordance with the KDADS HCBS Adverse Incident Monitoring SOP, KDADS PICS are responsible for monitoring AIRS on an ongoing basis, and identifying adverse events that require follow-up investigation or remediation within one business day of receiving the report through AIRS. KDADS conducts reviews on a quarterly basis to determine that participants have received education from their MCO on their ability and freedom to prevent or report information about Abuse, Neglect, Exploitation or Fiduciary Abuse in accordance with KDADS HCBS Adverse Incident Reporting and Management Policy and KDADS Adverse Incident Monitoring SOP.

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.
a. Use of Restraints. (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
• Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraints. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

• Methods for detecting use of restraint and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out (unsubstantiated) or screened in (substantiated). DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

A finding of “screened in” is given to reports that meet the statutory requirements for a DCF investigation, while “screened out” does not meet the statutory requirements for a DCF investigation. All screened out (unsubstantiated) and screened in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff. An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

All DCF determinations received by KDADS (screened in and screened out) are considered screened in adverse incidents by KDADS and are entered into the AIR system by KDADS for remediation and follow-up. The DCF determination informs KDADS on the appropriate investigation and remediation steps that should be taken by the MCOs. The significance of the DCF determination of screened in or out status is that, DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up.

• How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:
1) AIR performance data on each health and welfare performance measure as identified in each HCBS waiver
2) Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.)
3) Trend analysis on each adverse incident
4) Remediation efforts by health and welfare performance measure as identified in each HCBS waiver
5) Remediation efforts by each adverse incident

• The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.
• The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:
• Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents
• Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident
• Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards
Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
• Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restrictive interventions. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

• Methods for detecting the use of restrictive interventions and ensuring that all applicable state requirements are followed:

All adverse incidents (including all unauthorized use of restrictive interventions) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out (unsubstantiated) or screened in (substantiated). DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

All DCF determinations received by KDADS (screened in and screened out) are considered screened in adverse incidents by KDADS and are entered into the AIR system by KDADS for remediation and follow-up. The DCF determination informs KDADS on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

• How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3. Trend analysis on each adverse incident.
4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5. Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened-in and screened-out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

• The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

• The frequency of oversight:
Oversight is ongoing, as indicated in the AIR System Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

**MCO Adverse Incident Remediation Audit**

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1. Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2. Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3. Following up with MCOs to identify systemic concerns and address them through the implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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**Appendix G: Participant Safeguards**

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)**

**c. Use of Seclusion.** *(Select one):* *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
The use of restrictive intervention. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of and ensuring that all applicable state requirements are followed:

  All adverse incidents (including all uses of restrictive intervention) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out (unsubstantiated) or screened-in (substantiated). DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system. All DCF determinations received by KDADS (screened in and screened out) are considered screened in adverse incidents by KDADS and are entered into the AIR system by KDADS for remediation and follow-up. The DCF determination informs KDADS of the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes “screened in” classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

- How data are analyzed to identify trends and patterns and support improvement strategies:

  KDADS will monitor data within AIR to assess:

  1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
  2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
  3. Trend analysis on each adverse incident.
  4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
  5. Remediation efforts by each adverse incident.

  KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

  Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies. Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

- The frequency of oversight:

  Oversight is ongoing, as indicated in the AIR System Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:
MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1. Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2. Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3. Following up with MCOs to identify systemic concerns and address them through the implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate.

☐ The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

☐ No. This Appendix is not applicable (do not complete the remaining items)
☐ Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.
ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. Select one:

- Not applicable. *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. Select one of the following:

- Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).
  
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  *(empty box)*

  (b) Specify the types of medication errors that providers are required to record:

  *(empty box)*

  (c) Specify the types of medication errors that providers must report to the state:

  *(empty box)*
Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards
Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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 instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record Reviews
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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
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</tbody>
</table>
| Sub-State Entity | ✔ Quarterly | Representative Sample  
Confidence Interval = |
| ✔ Other  
Specify:  
KanCare Managed Care Organizations (MCOs) | Annually | Stratified  
Describe Group: |
| ✔ Continuous and Ongoing | Other  
Specify: | |
| Other  
Specify: | | |

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Specify: | ✔ Annually |
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<td>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</td>
<td>× Continuously and Ongoing</td>
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Performance Measure:
Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes

\[ \text{N} = \text{Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes} \]
\[ \text{D} = \text{Number of unexpected deaths} \]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record Reviews

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Performance Measure:
Number and percent of unexpected deaths for which the appropriate follow-up measures were taken

\[ N = \text{Number of unexpected deaths for which the appropriate follow-up measures were taken} \]
\[ D = \text{Number of unexpected deaths} \]

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews

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<td>Sub-State Entity</td>
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If 'Other' is selected, specify:

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<td>Proportionate by MCO</td>
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### 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

Responsible Party for 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

Frequency of data aggregation and analysis (check each that applies):

- Continuously and Ongoing

- Other

Specify:

Continuously and Ongoing

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- KanCare MCOs participate in analysis of this measure’s results as determined by the State operating agency

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):
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If 'Other' is selected, specify:
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### 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
- **D** = Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures

### Data Source (Select one):
- **Other**
  - Specifying

### Critical incident management system

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c. **Sub-assurance:** The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.

\[ N = \text{Number of unauthorized uses of restrictive interventions} \]

\[ D = \text{Number of unauthorized uses of restrictive interventions} \]

**Data Source** (Select one):

- **Other**
  
  If ‘Other’ is selected, specify:

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Other
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Annually

Continuously and Ongoing

Other
Specify:

**Performance Measure:**
Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver

N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
D=Number of restraint applications, seclusion or other restrictive interventions

**Data Source (Select one):**
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Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who have a disaster red flag designation with a related disaster red flag designation with a related disaster backup plan

N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
D=Number of waiver participants with a red flag designation.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
Record reviews

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### 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**

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems
   
i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation
   Remediation-related Data Aggregation and Analysis (including trend identification)
c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.
Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.
The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS’s Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful consumer feedback on the HCBS program. The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE’s Long-Term Care Committee and interagency monitoring team(s).

In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor’s systems as well as the Managed Care Organizations’ systems. On a routine basis, KDADS’ Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency’s critical incident management system. KDADS worked with Adult Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS’ Quality Management Specialists collect data, aggregate it, analyze it and provide information regarding discrepancies and trends to Program staff, Quality staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

### ii. System Improvement Activities

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07/05/2023
b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with Hewlett Packard (HP) to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and HP staff to generate recommended systems changes, which are then monitored and analyzed by HP and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Operating Agency has developed Quality Management staff and an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and to identify areas for improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (Select one):
b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey:
- NCI Survey:
- NCI AD Survey:
- Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.

b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) The Kancare MCO is responsible for conducting post payment review for payments. The MCO monitors claims payments to ensure members are receiving the services defined in the plan of care. If there were concerns regarding a provider’s billing practice, the MCO would conduct a claims audit which includes requesting provider documentation for services rendered. The MCO has ongoing audits for all services rendered to waiver members. Monthly MCO meetings occur with the MCOs, KDADS and KDHE staff and leadership. At these meetings, any concerns are shared, and follow-up is performed. Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1915(b) waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - are part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the interagency monitoring team(s), an important part of the overall state’s KanCare Quality Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.
The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas’ Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General’s Office. At a minimum, the CONTRACTOR shall:

a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;

b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;

c. Report immediately to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the
possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
(1) Oversight of the program integrity function under this contract;
(2) Liaison with the State in all matters regarding program integrity;
(3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
(4) Liaison with Kansas’ MFCU;
(5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

The State makes payment to the MCO based on the eligibility category assigned by the eligibility system, KEES. The eligibility file is loaded on a nightly basis to the MMIS. Any changes that occur to the participant’s eligibility are made in KEES, sent to the MMIS, and updated nightly. Capitation payments are made to the MCOs’ retrospectively. The reconciliation process in the MMIS with the 834 will catch the capitation error and recoup against the MCO payment.

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. Only Native American populations can opt out of managed care.

These claims could be pulled into a SURS audit. Audits could be conducted by SURS or by a federal entity such as PERM. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider is flagged as an outlier or for questionable billing practices.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post payment FFS claims audit. If there were concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered.

The Legislative Division of Post Audit (LPA) is the non-partisan audit arm of the Kansas Legislature.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract

\[ N = \text{Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract} \]

\[ D = \text{Total number of provider claims} \]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

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**Performance Measure:**

Number and percent of provider claims that are coded and paid in accordance with the state’s approved reimbursement methodology  

\[ N = \text{Number of provider claims that are coded and paid in accordance with the state’s approved reimbursement methodology} \]

\[ D = \text{Total number of provider claims paid.} \]

**Data Source (Select one):**

Other  
If ‘Other’ is selected, specify: State data system

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07/05/2023
b. **Sub-assurance:** The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Number and percent of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS throughout the five year renewal cycle. \( N = \text{number of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS} \)

\[ \text{D = Total number of capitation (payment) rates} \]

**Data Source (Select one):**

- Other

If 'Other' is selected, specify:

**State data systems**

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state established an inter-agency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the inter-agency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.

### b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

### ii. Remediation Data Aggregation

#### Remediation-related Data Aggregation and Analysis (including trend identification)

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### c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State Medicaid Agency and the Operating Agency will amend the performance measures to improve the quality improvement strategy in an amendment with an effective date of 05/01/2021.

### Appendix I: Financial Accountability

#### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).
Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes, and other relevant environmental and financial factors. The floor rates were last reviewed and revised effective 7/1/19 per State Policy when a rate adjustment was made effective. The adjustment was made available through legislative appropriation.

Capitation rates are based on actuarial analysis of historical data for all HCBS program services. These rates are set by the state’s contracted actuary and are based on historical claims and utilization. The state provides all appropriate data to the Actuary for the rate setting process. The Medicaid agency then sets the actuarial certified capitation rate within the range and the capitation rates are approved by CMS. The MCO’s are responsible for trending costs and demonstrating financial experience going forward. Based on the data collected, the MCO may request the State’s review for cost adjustments.

The State does not currently have a set timeframe for regular reviews of the FFS rates for Waiver services. However, there are periodic checks of the rates and utilization for each of the services on the waiver. The State has leveraged and will continue to leverage, multiple sources to assist in researching the adequacy of our rates. This would include strategies such as engaging with a consulting group to provide a rate study of surrounding states to benchmark where Kansas rates rank. The State also periodically requests that the MCOs review rates for similar services in other markets that they serve. Additionally, the State has open lines of communication with various provider groups and welcomes research performed by such groups as another data point. The goal of these studies is to ensure that the rates for waiver services are sufficient to encourage providers to continue serving the waiver population, thus maintaining network adequacy. The agency has the discretion to adjust the rates as they deem necessary; if the agency determines that a rate change is necessary, they would write a policy to change the fee schedule accordingly. Changing rates does not require legislative authority; however, since the legislature is the only body that can appropriate funds, the agency would need to request funding from the legislature to increase its budget to account for the increased spend associated with a rate change.

The state operating agency, in collaboration with the Medicaid agency, is responsible for rate determination and oversight of the process to ensure actuarially sound methods, including historical claims, are used to determine service rates. Under KanCare, the State sets the floor HCBS service rates, which serve as the minimum MCOs are required to pay providers. It should be noted that funding for rate increases requires legislative appropriation in Kansas.

The Operating Agency ensures FFS rates are adequate by ensuring a provider network is available in the rare event there is an opt-out from Managed Care. In the event, there are no FFS providers available due solely to the FFS rate, the state would make necessary adjustments to ensure providers are available.

The Operating Agency ensures public comment is available as rate adjustments are dependent on legislative appropriation which each year provides opportunity for public and stakeholder feedback and comments on rates during each legislative process.

FFS rates are publicly available via State Bulletins via the State’s KMAP website.

The KanCare program solicited public input when the program was developed which included the State setting the floor for service rates.

Waiver participants can obtain information about reimbursement rates for individual services by contacting their assigned MCO.

FFS rates can be found via State Bulletins via the State’s KMAP website.” An example, the notice for adjusted rates effective July 1, 2019 rates are included in the bulletin below.


Stakeholders can locate public notices and update the waiver accordingly via:

https://kdads.ks.gov/commissions/home-community-based-services-(hcbs)/proposed-waiver-renewals
b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state’s claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the MCOs directly from waiver provider agencies or from Financial Management Service (FMS) agencies for those individuals self-directing their services. All claims are either submitted through the EVV system, the State’s front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Claims for services required in the EVV system are generated from that system. Capitated payments in arrears are made only when the consumer was eligible for the Medicaid waiver program during the month. Claims furnished on an FFS basis is processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA. Only Native American populations can opt out of managed care

The Electronic Visit Verification (EVV) system is used to document time and attendance of service delivery. It captures and verifies worker’s identity, location, service time, type of service and Medicaid recipient. The system has the capability to generate a comprehensive report to monitor worker activity, claims submission and claims exceptions, including alerts of potential duplicate claims. Exceptions identified must be addressed prior to submitting HIPPA compliant claims as part of front end billing to managed care organizations for payment. When an integrated scheduler is used, the system has the capability to receive real-time alerts for late and missed visits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- No. state or local government agencies do not certify expenditures for waiver services.
- Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)
Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through the Kansas Eligibility Enforcement System (KEES). The state also is requiring the MCOs to utilize the State’s contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the consumer’s plan of care detailing authorized services. All mandated services must be billed through the EVV system. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1. Individuals (participants) must be determined to have met the program’s level of care criteria and Medicaid eligible prior to starting services.

Services delivered that are reimbursed through Medicaid payments are only for services that are authorized on the approved Plan of Care and within the service limitations written into the service descriptions.

These claims could be pulled into a SURS audit. Audits could be conducted by SURS. The Surveillance and Utilization Review Subsystem (SURS) team would submit a claim adjustment request to the fiscal agent Claims team for the recoupments. These recoupments would report on the CMS64 which is used to repay the FFP to CMS. The Surveillance and Utilization Review Subsystem (SURS) team would conduct an FFS claims audit when a provider is flagged as an outlier or for questionable billing practices. The State performs various reviews and audits of the MCOs regarding HCBS including but not limited to report reviews, quarterly case file reviews, annual reviews, provider qualification reviews to determine whether services were provided.

DXC, the MMIS fiscal agent, would perform the FFS post-payment review. There are currently no FFS members in the waiver. If there were FFS members, the state program integrity manager would request the Surveillance and Utilization Review Subsystem (SURS) team with the Medicaid fiscal agent to conduct a post-payment FFS claims audit. If there were concerns regarding a provider’s billing practice, the (SURS) team would conduct an FFS claims audit which includes requesting provider documentation for services rendered.

The KanCare MCO is responsible for conducting a post-payment review for payments. The MCO monitors claims payments to ensure members are receiving the services defined in the plan of care. If there were concerns regarding a provider’s billing practice, the MCO would conduct a claims audit which includes requesting provider documentation for services rendered.

The MCO has ongoing audits for all services rendered to waiver members. Monthly MCO meetings occur with the MCOs, KDADS and KDHE staff and leadership. At these meetings, any concerns are shared, and follow-up is performed.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver services are made through an approved MMIS.
Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

There have been no FFS claims outside of the capitated rate for the last 5 years and the state does not anticipate there will be FFS claims in future years.

Only Native American populations can opt-out of managed care.

FFS providers have the option to be paid via a check or through EFT. Payment is made based on the provider’s preference.

All other claims paid outside of the MMIS system are paid to the MCOs through a per member per month capitated payment. The claim is received and processed through the MMIS Claims Engine. The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions
that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency
oversees the operations of the limited fiscal agent:

Claims furnished on an FFS basis are processed through the claim’s engine, electronic MMIS system, based on the
beneficiary’s benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA
should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or
does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or
the rate on the PA.

Only Native American populations can opt-out of managed care.

In the event an FFS participant chose to Self-Direct their services; those services would be provided by an FMS
provider that is enrolled with the Medicaid Program that would act as a limited fiscal agent between the state and
the participant/employer.

Providers are paid by a managed care entity or entities for services that are included in the state’s contract with the
entity.

Specify how providers are paid for the services (if any) not included in the state’s contract with managed care
entities.

All of the waiver services in this program are included in the state’s contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with
efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for
expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are
made. Select one:

- No. The state does not make supplemental or enhanced payments for waiver services.
- Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which
these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-
Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the
supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS.
Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or
enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment
for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that
the state or local government providers furnish:

In the event there was an FFS opt out and a local government entity was a service provider, the local entity would be reimbursed the same amount as a private provider.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Anyone received their services through FFS, the provider would retain 100% of the amount claimed.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:
No. The state does not provide that providers may voluntarily reassign their right to direct payments
to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as
provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements
  under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under
  the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for
designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not
voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have
free choice of qualified providers when an OHCDS arrangement is employed, including the selection of
providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services
under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is
assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial
accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s)
  (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the
delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services
through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state
Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the
geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d)
how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver
and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory
health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how
payments to these plans are made.

- This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and
other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health
plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these
plans are made.

- If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

The non-federal share of the waiver expenditures is from direct state appropriations to the operating agency. The non-federal share of the waiver expenditures is directly expended by KDADS. Both capitated rates and FFS Medicaid claim payments are processed by the State’s fiscal agent through the MMIS using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS’s reporting module to identify payments made by each agency. DHCF-KDHE draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on FFS claims and capitation payments in the KanCare program.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

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.

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
b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

When establishing reimbursement rates as described in Appendix I-2.a, no expenses associated with room and board are considered.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver’s home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- No. The state does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:
Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

- Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols.
4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

### Level(s) of Care: Nursing Facility

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<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column 4)</th>
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<td>34394.00</td>
<td>8032.41</td>
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</tbody>
</table>

### 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:

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<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
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<td>Year 5</td>
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</table>

#### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) estimate is derived from the unduplicated participants and days of waiver enrollment from the approved CMS-372 reports for calendar year 2016. The ALOS was projected by dividing 2,182,347 (the days of waiver enrollment) by 6,898 (unduplicated participants). The projected average length of stay for this renewal is 316.

#### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

---

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:
Factor D is estimated by using actual MCO encounter data from the Medicaid Management Information System (MMIS) of the Home and Community Based Services waiver service cost and utilization for the Physical Disability waiver participants. Actual MCO encounter payments were utilized in order to estimate the state cost of Factor D as part of an all-inclusive capitated payment. The MCO encounter data was used to establish the estimated number of users and utilization which was averaged over the three-year period. The state utilized the most recent cost per unit data at the time the Waiver renewal was prepared to ensure most current cost data was recognized. Factor D’ estimates do not include the cost of prescribed drugs that are furnished to dual-eligible under the provisions of Medicare Part D. This is not a Medicaid cost, and it is not paid through the MMIS.

For the waiver renewal period, there is no annual trending applied to the unit cost for Factor D. The State does not currently anticipate that there will be a significant change in rates over the next five years as the rate adjustments are subject to legislative appropriation. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

ii. Factor D’ Derivation. The estimates of Factor D’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For the waiver renewal period, there is no annual trending applied to the unit cost for Factor D’. The State does not currently anticipate that there will be a significant change in rates over the next five years as the rate adjustments are subject to legislative appropriation.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

In Kansas Factor G’ has historically been greater than D’. This is primarily attributed to the costs of hospice services being included as part of the State Plan G’ services. Approximately 50% of G’ costs are attributed to hospice services.

Based on analysis of actual MCO encounter claims, the estimates for D’ for the prior period were over estimated by approximately $500. The actual average for CY15 through CY17 was approximately $2,700 while estimates were around $3,200.

For the waiver renewal period, there is no annual trending applied to the unit cost for Factor D’. The State does not currently anticipate that there will be a significant change in rates over the next five years as the rate adjustments are subject to legislative appropriation.
Factor G is estimated by utilizing actual MCO encounter data from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of the nursing facility utilization for nursing facility participants which is trended with the most current cost information.

For the waiver renewal period, there is no annual trending applied to Factor G. The State has not included any assumptions that there will be a significant change in institutional costs over the next five years for this population. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

The State cannot use the CMS-372 reports to estimate Factor G because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs. The State used encounter data from the MMIS as the base data in the derivation of Factor G to most accurately represent the cost associated with those served in the institutional equivalent.

Factor G is estimated by utilizing MCO encounter data from the Medicaid Management Information System (MMIS) and reflects a three-year average (CY2015 through CY2017) of utilization and persons served for all other Medicaid services furnished while the individual is institutionalized. The averages are trended with most current cost data.

For the waiver renewal period, there is no annual trending applied to Factor G'. The State does not currently anticipate that there will be a significant change in rates over the next five years. It should also be noted that floor rates in Kansas Medicaid are determined by legislative appropriation.

Factor G' estimates do not include the cost of prescribed drugs that are furnished to dual eligible under the provisions of Medicare Part D. This is not a Medicaid cost, and it is not paid through the MMIS.

The State cannot use the CMS-372 reports to estimate Factor G', because the figures reported via the CMS-372 were the same as the figures in the previously approved waiver, rather than actual costs. The State used MCO encounters data from the MMIS as the base data in the derivation of Factor G' to most accurately represent the cost associated with those served in the institutional equivalent.

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:

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.

<table>
<thead>
<tr>
<th>Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Services</td>
</tr>
<tr>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Assistive Services</td>
</tr>
<tr>
<td>Enhanced Care Service</td>
</tr>
</tbody>
</table>
### 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

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Capi-</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td>84768014.12</td>
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<td>×</td>
<td>15 minutes</td>
<td>1611</td>
<td>3316.57</td>
<td>3.40</td>
<td>18166189.52</td>
<td></td>
</tr>
<tr>
<td>Personal Services - Self-Directed</td>
<td>×</td>
<td>15 minutes</td>
<td>4851</td>
<td>4669.90</td>
<td>2.94</td>
<td>66601833.61</td>
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</tr>
<tr>
<td>Financial Management Services Total:</td>
<td>×</td>
<td>1 month</td>
<td>4911</td>
<td>9.69</td>
<td>128.59</td>
<td>6119288.20</td>
<td></td>
</tr>
<tr>
<td>Assistive Services Total:</td>
<td>×</td>
<td>1 purchase</td>
<td>123</td>
<td>1.28</td>
<td>2106.92</td>
<td>331713.48</td>
<td></td>
</tr>
<tr>
<td>Home-Delivered Meals Service Total:</td>
<td>×</td>
<td>1 meal</td>
<td>1998</td>
<td>343.51</td>
<td>6.07</td>
<td>4166041.19</td>
<td></td>
</tr>
<tr>
<td>Medication Reminder Services Total:</td>
<td>×</td>
<td>1 month</td>
<td>3</td>
<td>1.00</td>
<td>31.88</td>
<td>61852.48</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

Total: Services included in capitation: 113917644.39
Total: Services not included in capitation: 113917644.39
Total Estimated Unduplicated Participants: 6998
Factor D (Divide total by number of participants): 16514.59
Services included in capitation: 16514.59
Services not included in capitation: 16514.59

**Average Length of Stay on the Waiver:** 316
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
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<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
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<tbody>
<tr>
<td>Reminder/Dispenser/Installation</td>
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<tr>
<td>Personal Emergency Response System and Installation Total:</td>
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<td></td>
<td></td>
<td></td>
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<td>33509.92</td>
</tr>
<tr>
<td>GRAND TOTAL:</td>
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<td></td>
<td></td>
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<tr>
<td>Total: Services included in capitation:</td>
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<td></td>
<td></td>
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<td>113917644.39</td>
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<tr>
<td>Total: Services not included in capitation:</td>
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<td></td>
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<td></td>
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<td>698</td>
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<tr>
<td>Total Estimated Unduplicated Participants:</td>
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<td></td>
<td></td>
<td></td>
<td>6898</td>
</tr>
<tr>
<td>Factor D (Divide total by number of participants):</td>
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<td>16514.59</td>
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<tr>
<td>Services included in capitation:</td>
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<td>316</td>
</tr>
</tbody>
</table>

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**Application for 1915(c) HCBS Waiver: Draft KS.014.05.04 - Jan 01, 2024**  
07/05/2023  
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## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 3

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Enhanced Care Service</td>
<td>×</td>
<td>I unit</td>
<td>1164</td>
<td>231.43</td>
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<td>17299873.87</td>
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<td>4166041.19</td>
<td>4166041.19</td>
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<tr>
<td>Home-Delivered Meals Service</td>
<td>×</td>
<td>I meal</td>
<td>1998</td>
<td>343.51</td>
<td>6.07</td>
<td>4166041.19</td>
<td>4166041.19</td>
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<td>63774.02</td>
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<td>1.00</td>
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<td>95.64</td>
<td>95.64</td>
</tr>
<tr>
<td>Medication Reminder/Dispenser</td>
<td>×</td>
<td>I month</td>
<td>265</td>
<td>7.88</td>
<td>29.62</td>
<td>61852.48</td>
<td>61852.48</td>
</tr>
<tr>
<td>Medication Reminder/Dispenser/Installation</td>
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<td>I installation</td>
<td>62</td>
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<td>29.45</td>
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<td></td>
<td>1168939.50</td>
<td>1168939.50</td>
</tr>
<tr>
<td>Personal Emergency Response System</td>
<td>×</td>
<td>I month</td>
<td>3205</td>
<td>8.58</td>
<td>41.29</td>
<td>1135429.58</td>
<td>1135429.58</td>
</tr>
<tr>
<td>Personal Emergency Response System Installation</td>
<td>×</td>
<td>I installation</td>
<td>584</td>
<td>1.00</td>
<td>57.38</td>
<td>33509.92</td>
<td>33509.92</td>
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<td><strong>GRAND TOTAL:</strong></td>
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<td>113917644.39</td>
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<tr>
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<tr>
<td><strong>Total Estimated Unduplicated Participants:</strong></td>
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<td>Factor D (Divide total by number of participants):</td>
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<td></td>
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<td>16514.59</td>
<td>16514.59</td>
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<td>Services included in capitation:</td>
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<td>16514.59</td>
<td>16514.59</td>
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<tr>
<td>Average Length of Stay on the Waiver:</td>
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<td></td>
<td></td>
<td>316</td>
<td>316</td>
</tr>
</tbody>
</table>

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**Application for 1915(c) HCBS Waiver: Draft KS.014.05.04 - Jan 01, 2024**

**Page 204 of 207**

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**07/05/2023**
<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal Services - Self-Directed</strong></td>
<td>×</td>
<td>15 minutes</td>
<td>4851</td>
<td>4669.90</td>
<td>2.94</td>
<td>66601833.61</td>
<td>619288.20</td>
</tr>
<tr>
<td><strong>Financial Management Services</strong> Total:</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assistive Services Total:</strong></td>
<td>×</td>
<td>1 purchase</td>
<td>123</td>
<td>1.28</td>
<td></td>
<td>2106.92</td>
<td></td>
</tr>
<tr>
<td><strong>Enhanced Care Service Total:</strong></td>
<td>×</td>
<td>1 unit</td>
<td>1164</td>
<td>231.43</td>
<td>64.22</td>
<td>17299873.87</td>
<td></td>
</tr>
<tr>
<td><strong>Home-Delivered Meals Service Total:</strong></td>
<td>×</td>
<td>1 meal</td>
<td>1998</td>
<td>343.51</td>
<td>6.07</td>
<td>4166041.19</td>
<td></td>
</tr>
<tr>
<td><strong>Medication Reminder Services Total:</strong></td>
<td>×</td>
<td>1 month</td>
<td>3</td>
<td>1.00</td>
<td></td>
<td>31.88</td>
<td>95.64</td>
</tr>
<tr>
<td><strong>Medication Reminder/Dispenser</strong></td>
<td>×</td>
<td>1 month</td>
<td>265</td>
<td>7.88</td>
<td></td>
<td>29.62</td>
<td>61852.48</td>
</tr>
<tr>
<td><strong>Medication Reminder/Dispenser/Installation</strong></td>
<td>×</td>
<td>1 installation</td>
<td>62</td>
<td>1.00</td>
<td></td>
<td>29.45</td>
<td>1825.90</td>
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<tr>
<td><strong>Personal Emergency Response System and Installation Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1168939.50</td>
</tr>
<tr>
<td><strong>Personal Emergency Response System</strong></td>
<td>×</td>
<td>1 month</td>
<td>3205</td>
<td>8.58</td>
<td></td>
<td>41.29</td>
<td>1135429.58</td>
</tr>
<tr>
<td><strong>Personal Emergency Response System Installation</strong></td>
<td>×</td>
<td>1 installation</td>
<td>584</td>
<td>1.00</td>
<td></td>
<td>57.38</td>
<td>33509.92</td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

Total: Services included in capitation: 113917644.39
Total: Services not included in capitation: 113917644.39
Total Estimated Unduplicated Participants: 6898
Factor D (Divide total by number of participants): 16514.59
Services included in capitation: 16514.59
Services not included in capitation: 16514.59
Average Length of Stay on the Waiver: 316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

<table>
<thead>
<tr>
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<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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</thead>
<tbody>
<tr>
<td>Personal Care Services Total:</td>
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<td></td>
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</tr>
<tr>
<td>Personal Care Services - Agency-Directed</td>
<td>✗</td>
<td>1/5 minutes</td>
<td>1611</td>
<td>3316.57</td>
<td>3.40</td>
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<td>Personal Services - Self-Directed</td>
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<td>Financial Management Services</td>
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<td>1 month</td>
<td>4911</td>
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<td>Assistive Services Total:</td>
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<tr>
<td>Assistive Services</td>
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<td>1 purchase</td>
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<td>1.28</td>
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<td>Home-Delivered Meals Service</td>
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</tr>
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<td>29.45</td>
<td>1825.90</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personal Emergency Response System</td>
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<td>1 month</td>
<td>3205</td>
<td>8.58</td>
<td>41.29</td>
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</tr>
<tr>
<td>Personal Emergency Response System Installation</td>
<td>✗</td>
<td>1 installation</td>
<td>584</td>
<td>1.00</td>
<td>57.38</td>
<td>33509.92</td>
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</tr>
</tbody>
</table>

**GRAND TOTAL:**

113917644.39

Total: Services included in capitation:

113917644.39

Total: Services not included in capitation:

6898

Total Estimated Unduplicated Participants:

1651439

Factor D (Divide total by number of participants):

1651439

Services included in capitation:

6898

Services not included in capitation:

1651439

Average Length of Stay on the Waiver:

316
### Waiver Year: Year 5

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care Services Total:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Personal Services - Agency-Directed</td>
<td>×</td>
<td>15 minutes</td>
<td>1611</td>
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<td>3.40</td>
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<tr>
<td>Personal Services - Self-Directed</td>
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<td>15 minutes</td>
<td>4851</td>
<td>4669.90</td>
<td>2.94</td>
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<td><strong>Financial Management Services Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>×</td>
<td>1 month</td>
<td>4911</td>
<td>9.69</td>
<td>128.59</td>
<td>6119288.20</td>
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<td><strong>Assistive Services Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistive Services</td>
<td>×</td>
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<td>123</td>
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<td></td>
<td>2106.92</td>
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<tr>
<td><strong>Enhanced Care Service Total:</strong></td>
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<tr>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Medication Reminder</td>
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<tr>
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<tr>
<td>Personal Emergency Response System Installation</td>
<td>×</td>
<td>1 installation</td>
<td>584</td>
<td>1.00</td>
<td>57.38</td>
<td>33509.92</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:** 113917644.39

- Total: Services included in capitation: 113917644.39
- Total: Services not included in capitation: 6898
- Total Estimated Unduplicated Participants: 6898
- Factor D (Divide total by number of participants): 16524.59
- Services included in capitation: 16524.59
- Services not included in capitation: 6898
- Average Length of Stay on the Waiver: 316
Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of Kansas requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
   Serious Emotional Disturbance (SED) Waiver

C. Waiver Number: KS.0320
   Original Base Waiver Number: KS.0320.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
   01/01/24

   Approved Effective Date of Waiver being Amended: 04/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

To align this waiver with the submission of the State's 1915(b) application.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Application</td>
<td></td>
</tr>
<tr>
<td>Appendix A</td>
<td></td>
</tr>
<tr>
<td>Waiver Administration and Operation</td>
<td></td>
</tr>
<tr>
<td>Appendix B</td>
<td></td>
</tr>
</tbody>
</table>
### B. Nature of the Amendment

Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other
  Specify:

---

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

- **A. The State of Kansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (optional - this title will be used to locate this waiver in the finder):

Serious Emotional Disturbance (SED) Waiver

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

- 3 years
- 5 years

Original Base Waiver Number: KS.0320
Draft ID: KS.009.05.02

D. Type of Waiver (select only one):

- Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/22
   Approved Effective Date of Waiver being Amended: 04/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

- Hospital
  Select applicable level of care
  - Hospital as defined in 42 CFR §440.10
    If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

- Inpatient psychiatric facility for individuals age 21 and under as provided in 42 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:

This amendment is being submitted simultaneously with the 1915(b) application.

Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:
This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Serious Emotional Disturbance (SED) Waiver is designed as a hospitalization diversion program. The goal of the SED waiver is to divert psychiatric hospitalization through the provision of intensive home and community based support services in an effort to maintain children and participant in their homes and communities.

The Kansas SED waiver provides six services to participants and their families that are not available to other Medicaid participant. These services are: wraparound facilitation, short term respite care, attendant care, independent living/skills building, parent support and training, and professional resource family care. Participants eligible for the waiver are between the ages of 4 and 18. An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through age 21 who are experiencing a serious emotional disturbance and are at risk for inpatient psychiatric hospitalization. Foster Care children on the SED waiver will not be able to access short term respite care or professional resource family care. The foster care contractor is able to arrange for the foster care participant/to access those two services through their contract with the state.

Both clinical and financial criteria must be met to be eligible for the waiver. The clinical assessment is a multi-step process. A participant must have a mental health diagnosis determined by a Qualified Mental Health Professional (QMHP) and qualifying scores on two standardized assessment tools. These tools are the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL). Financial eligibility is determined by the Kansas Department of Health and Environment (KDHE).

The SED waiver is managed by the Operating Agency, the Kansas Department for Aging and Disability Services. SED Waiver services are provided by 25 Community Mental Health Centers (CMHCs) and two affiliated organizations.

Each waiver participant will have a Person Centered Service Plan, (Service Plan). The Service Plan is developed by the Managed Care Organization (MCO) and will describe waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written Service Plan. The Service Plan will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written Service Plan.

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.


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 inpatients 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:
The Public Input was October 1, 2021 through November 15, 2021. SED Waiver Renewal Public Comment hosted by Wichita State University and lead by KDADS staff were held three different times: Tuesday October 26, Wednesday, October 27, October 28 in the evening. All public comments can be found at https://kdads.ks.gov/kdads-commissions/long-term-services-supports/ltss-public-comment-section. There were a total of 17 public comments, below is a sample.

Commenter: HCBS Provider - Can we change the language for the TCM and WAF at the same time to the "same person can not bill TCM and wraparound facilitation at the same time"? That would apply to the last sentence of the WAF definition (first paragraph) and the comment about the TCM and WAF should not be the same person. I think that would be much clearer for the point you are trying to make IF I am clearly understanding that correctly. The way it is currently written the TCM and WAF can not be working on different tasks at the same time (WAF contacting families to reschedule the wraparound meeting and TCM working on helping the family find resources they need) nor can a WAF in Western Kansas where they have fewer staff deliver timely service to a client because they have to wait on someone else to get the information and complete the task (instead WAF could finish their phone calls to set up wraparound meeting and then switch to billing TCM to call and find out who has food resources this month since family expressed that need when on the phone with the WAF). When you say that it cannot be the same person at the same time, that very clearly says the same person is not billing two codes at the same time. It says that those of two very different services with very different purposes that can not be done at the same time by one person.

KDADS Response: KDADS revised the waiver language to make a clearer delineation on how to conduct billing for WAF and TCM.

Commenter: Other Stakeholder - I am assuming then also that the wraparound facilitator and targeted case manager not being the same person is actually not the same person at the same time.

KDADS Response: Correct. If they’re not the same person. It just can’t be the same person billing both codes at same time, they need to be separate people.

Commenter: Other Stakeholder - When we are getting a client onto Medicaid, but they aren’t on the waiver yet, sometimes this takes time and we can’t bill for TCM since we are going to end up being the wraparound facilitator. Should we continue to provide this service as a no-bill, or should we provide this service as targeted case management since they aren’t on the waiver yet?

KDADS Response: Bill TCM if they have a Medicaid card and not yet on the waiver. If they do not yet have a Medical care it is a no-bill situation.

Commenter: Other Stakeholder - What if is the parent’s preference to meet via telehealth for wraparound facilitation meetings?

KDADS Response: They can certainly do that. They are required to meet face-to-face once a year when we are outside of the pandemic. Telehealth is fine now, but out of a public health emergency there is a requirement for the coordinators to meet face-to-face once a year.

Commenter: Other Stakeholder - It would be great if that waiver medical card could be put on pause should a waiver participant have a residential stay so that services can start up in a timely matter. I have had so many more transfers recently. I don’t know why more people are moving around but it is something we’ve noticed as an agency. It gets difficult sometimes to navigate all of the transfers. Even though it’s a draft the manual that speaks to the transfers has been helpful. It’s hard because sometimes the notification comes from the MCO, sometimes the family, sometimes the previous CMHC. Sometimes the previous CMHC doesn’t have a release, just verbal consent. It feels like there needs to be more help with the transfer section. Maybe create a 3161 specifically for transfers. Sometimes I don’t have any information except the client’s name and I have to contact multiple people to get updated contact information. If we can create a new document that shows their contact information that can be transmitted through agency mailboxes. KMIS is helpful but there would need to be a way to get all of those documents submitted. Anything to streamline transfer cases would be helpful.

KDADS Response: KDHE does not need a 3161 with someone who is within the state. If you could work with other CMHCs and come up with a proposal on inter-state transfers we would want to hear about it and see if we can help you with that.

Commenter: Other Stakeholder - The Provisional Plan of Care is not effective now until financial eligibility but that would be awesome. Problem will be if the process starts in one month but is approved in the following month.

KDADS Response: It’s a difficult challenge. Until they are actually eligible for the waiver, they aren’t eligible for services.

07/05/2023
We are trying to close this gap as much as we can. There have been improvements in the last year or so getting eligibility determined much more quickly. We’ll continue to work through this.

Commenter: Other Stakeholder - Does the MCO have to be face-to-face at wraparound facilitation meetings? Does everyone involved have to be present face-to-face? And as the CMHC, we usually lead meetings because we provide direct services and have the rapport. But we know the MCOs are now responsible for Person Center Service Plans and PII. Who should be leading the meeting. How should that work?
KDADS Response: The MCO care coordinator and the wraparound facilitator must meet in-person at least once a year with members. And we hold the MCOs accountable for having the meetings and making sure paperwork is submitted. I think it depends on each meeting who leads.

Notice to Tribal Governments: We received no comments from the Tribal governments.

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.


7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Weiter
First Name: Kurt
Title: Waiver Manager
Agency: Kansas Department of Health and Environment.
Address: 900 SW Jackson, Room 900 N
City: Topeka
State: Kansas
Zip: 66612-1220
Phone: (785) 296-8623 Ext: TTY
B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Heller-Workman, LBSW
First Name: Angela
Title: SED Waiver Program Manager
Agency: Kansas Department for Aging and Disability Services Community Supports and Services
Address: 503 S Kansas Ave
City: Topeka
State: Kansas
Zip: 66603
Phone: (785) 296-6843 Ext: TTY
Fax: (785) 296-0256
E-mail: Angela.HellerWorkman@ks.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: State Medicaid Director or Designee
Submission Date: 

Note: The Signature and Submission Date fields will be automatically completed when the State
Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

- Lowered eligibility for independent Living and Skills Building to age 14

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings...
requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance. Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state’s HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter “Completed” in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state’s most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan. Kansas is committed to an HCBS services environment that reflects the characteristics of ensuring choice of services and providers, privacy, autonomy, community access and integration for our waiver participants in compliance with the Final Settings Rule.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (select one):

- The waiver is operated by the state Medicaid agency.

  Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):

  - The Medical Assistance Unit.

    Specify the unit name:

    (Do not complete item A-2)

  - Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

    Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

    (Complete item A-2-a).

- The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

  Specify the division/unit name:
Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, State Plan Amendments (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 the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies’ leadership.) The state leadership-level meetings occur weekly and additional meetings occur as needed.

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
   - Information received from CMS;
   - Proposed policy changes;
   - Waiver amendments and changes;
   - Data collected through the quality review process
   - Eligibility, numbers of providers being served
   - Fiscal projections; and
   - Any other topics related to the waivers and Medicaid.

b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.

c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.

d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the program and the KanCare MCO contracts, and does collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration has been through the long term care meetings, KanCare Steering meetings, joint policy meetings, are all important parts 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 the program, and the interagency monitoring (including the SSMA’s monitoring of delegated functions to the Operating Agency) is guided by the joint long term care (LTC) meetings. A critical component of that strategy is the engagement of the LTC stakeholders, 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 LTC meetings – is on a quarterly basis. Continuous monitoring is being conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure.

All oversight activities delegated by KDHE to KDADS are expressly identified in the standard operating procedures as well as in the body of the Memorandum of Understanding (MOU) between KDHE and KDADS. The MOU will be reviewed and updated at a minimum 5 years from the effective date (section XIV.a). This does not preclude the parties from reviewing and updating the MOU at any time after the effective date by mutual agreement of the parties. Also the SOP’s can be updated at any time without having to amend the MOU.

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:

The assessing entity is a contracted entity to complete the waiver enrollment request with the participants and submits the request to KDADS for processing. The assessing entity is a contracted entity to provide the level of care assessment and upon completion submitting them to KDADS for determination. The waiver determination is made by KDADS and KDHE for all initial eligibility and continued eligibility requests.

The MCOs’ engage the child and family, or responsible adult, to develop a Person-Centered Service Plan for the participant. The MCO’s are responsible for ensuring paid support staff or other professionals carry out the Service Plan that supports the child’s functional development and inclusion in the community. Once the MCOs complete the Person-Centered Service Plan with the child and family, or responsible adult, a review is completed to ascertain the specific services, frequency and duration required to meet the needs of the child as identified in the service plan. Some approved waiver services do require prior authorizations before the services are administered. The MCOs’ provide utilization management and oversight of the service plans for waiver participants.

KDHE contracts with a Medicaid Fiscal agent to enroll providers in the Medicaid program in compliance with federal law. The Medicaid fiscal agent and KDHE review the provider application prior to approving the provider’s enrollment in the Medicaid program. The MCOs contract and credential providers within their network.

KDHE contracts with an EQRO to perform the EQRO defined functions for managed care.

The KDHE DHCF contracted actuary analyzes the MCOs’ paid claims to determine the capitation rate (PMPM) for the SED waiver.

KDHE DHCF’s contract with the MCOs requires the MCOs to provide medically necessary services to eligible Medicaid members. The MCOs’ are contractually required to provide reporting to the State and address quality concerns.

○ 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:

KS has 26 Community Mental Health Centers (CMHCs) established under the provisions of the following state statute 2020 KS Statute, KSA 19 4001, and approved by the Secretary for Aging and Disability Services. The 26 CMHC’s hold yearly contracts through the KDADS Behavior Health Department which is mandated by the State Legislators through Kansas Statutes. CMHCs are responsible for the provision of mental health services in Kansas. The Centers are responsible for specific geographic areas throughout the state and are procured through the state’s contracting process. Two of the CMHC’s are local public governmental agencies. Twenty-four of the CMHC’s are non-governmental state entities.

The CMHCs first complete a general intake/assessment on all participants to determine if the participant has a Serious Emotional Disturbance. Next, therapists would administer additional assessment tools to establish waiver eligibility. KDADS delegated the assessment functions to the CMHCs for SED potential participants and current participants via K.S.A. 39-1610, which states that each mental health center entering a contract with the secretary shall provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the care and treatment act for mentally ill persons. KDADS contracts with the Community Mental Health Centers on a yearly basis. The CMHC’s assist in waiver enrollment by providing the assessment function to start the waiver enrollment process. Once SED waiver level of care assessment is administered the CMHC’s submits the LOC assessment to KDADS to determine program eligibility. The CMHC’s Qualified Mental Health Practitioner conducts the initial LOC assessments which the SED waiver potential participant to determine waiver eligibility. KDADS Program Manager approves waiver access and sends to Kansas Department for Health and Environment (KDHE) to determine financial eligibility. KDADS Program reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on those approved and met LOC criteria. The 3160 designated program eligibility form is complete and sent on to the KDHE eligibility department for the financial determination. KDHE then notifies the MCO and CMHC of the final eligibility and if approved, the start date of waiver services. KDHE sends completed eligibility packet to the chosen Managed Care Organization (MCO) and back to KDADS. KDHE Waiver Managers review monthly reports from the Program Manager which notes the current numbers for the SED Waiver participant.

The CMHCs and MCO’s are both responsible for quality assurance and quality improvement activities. The state's contracted MCOs conduct Service Plan development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manuals, and other provider guidance; and participate in the comprehensive state quality improvement strategy. The state's Community Mental Health Centers (CMHC) conduct waiver assessment for current and potential participants. The MCO and CMHC meet with the participant and participant's family at initially and then every 90 days to review the Person-Centered Service Plan. The Person-Centered Service Plan Team meet with the participant to review goals and the need for continued waiver services to meet their defined goals. These is determined through the CMHC's conducing a Level of care assessment annually. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. The participant's Annual LOC documents are uploaded by the CMHCs into KDADS KAMIS reporting system for KDADS review. The KDADS Quality Review Team reviews a sample of the CMHC’s reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver.

KDADS reviews and approves documentation for functional eligibility and the Single State Medicaid Agency (KDHE) approves financial eligibility. KDHE holds the contract for the Managed Care Organizations. KDHE hold regular quality assurance and oversight activities for the MCOs’. KDHE contracts with KFMC to perform EQRO functions. KDADS completes quarterly Performance Measure reviews for both the assessing entities and the MCOs.

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
KS has 26 Community Mental Health Centers (CMHCs) established under the provisions of the following state statute 2020 KS Statute, KSA 19 4001, and approved by the Secretary for Aging and Disability Services. The 26 CMHC’s hold yearly contracts through the KDADS Behavior Health Department which is mandated by the State Legislators through Kansas Statutes. CMHCs are responsible for the provision of mental health services in Kansas. The Centers are responsible for specific geographic areas throughout the state and are procured through the state’s contracting process. Two of the CMHC’s are local public governmental agencies. Twenty-four of the CMHC’s are non-governmental state entities.

The CMHCs first complete a general intake/assessment on all participants to determine if the participant has a Serious Emotional Disturbance. Next, therapists would administer additional assessment tools to establish waiver eligibility. KDADS delegated the assessment functions to the CMHCs for SED potential participants and current participants via K.S.A. 39-1610, which states that each mental health center entering a contract with the secretary shall provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the care and treatment act for mentally ill persons. KDADS contracts with the Community Mental Health Centers on a yearly basis. The CMHC’s assist in waiver enrollment by providing the assessment function to start the waiver enrollment process. Once SED waiver level of care assessment is administered the CMHC’s submits the LOC assessment to KDADS to determine program eligibility. The CMHC’s Qualified Mental Health Practitioner conducts the initial LOC assessments which the SED waiver potential participant to determine waiver eligibility. KDADS Program Manager approves waiver access and sends to Kansas Department for Health and Environment (KDHE) to determine financial eligibility. KDADS Program reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on those approved and met LOC criteria. The 3160 designated program eligibility form is complete and sent on to the KDHE eligibility department for the financial determination. KDHE then notifies the MCO and CMHC of the final eligibility and if approved, the start date of waiver services. KDHE sends completed eligibility packet to the chosen Managed Care Organization (MCO) and back to KDADS. KDHE Waiver Managers review monthly reports from the Program Manager which notes the current numbers for the SED Waiver participant.

The CMHCs and MCO’s are both responsible for quality assurance and quality improvement activities. The state's contracted MCOs conduct Service Plan development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manuals, and other provider guidance; and participate in the comprehensive state quality improvement strategy. The state's Community Mental Health Centers (CMHC) conduct waiver assessment for current and potential participants. The MCO and CMHC meet with the participant and participant's family at initially and then every 90 days to review goals and the need for continued waiver services to meet their defined goals. These is determined through the CMHC's conducing a Level of care assessment annually. The annual level of care continues to require aQMHP as the assessor and is based on current diagnosis and level of functioning. The participant's Annual LOC documents are uploaded by the CMHCs into KDADS KAMIS reporting system for KDADS review. The KDADS Quality Review Team reviews a sample of the CMHC’s reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver. KDADS reviews and approves documentation for functional eligibility and the Single State Medicaid Agency (KDHE) approves financial eligibility. KDHE holds the contract for the Managed Care Organizations. KDHE hold regular quality assurance and oversight activities for the MCOs’. KDHE contracts with KFMC to perform EQRO functions. KDADS completes quarterly Performance Measure reviews for both the assessing entities and the MCOs.

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:
KDHE holds the contract for the Managed Care Organizations. They hold regular quality assurance and oversight activities for the MCOs’. KDHE contro perform EQRO functions. The CMHCs first complete a general intake/assessment on all participants to determine if the participant has a Serious Emotional Disturbance. Next, therapists would administer additional assessment tools to establish waiver eligibility. KDHE is responsible for the financial eligibility before the participants are granted access to the waiver. KDHE issues eligibility determination letters and appeal rights if not found eligible.

The State contracts with a number of entities to assist with carrying out needed waiver administration and operation activities.

- **Level of care evaluation (initially, annually and when there is a change in condition)**: Assessment is completed by the CMHC. Determination is made by KDADS. KDADS oversees this eligibility function through their QA process.
- **Review of participant service plans**: KDHE contracts with an EQRO to review MCO’s contracts and compliance with those contracts. KDADS participates in the contract review process headed by KDHE. KDADS also has a QA process and produces a quarterly QA report reviewed by KDHE. Each MCO has an internal PCSP review process.
- **Prior authorization of waiver services**: KDHE provides oversight of the prior authorization systems. KDHE through their clinical team including the Medicaid Medical Director work with the MCOs through the annual MCO contractual audit. The KDHE staff and the KDADS staff participate in the annual contract review.
- **Utilization management**: The MCOs provide UM services in oversight of the service plans for waiver participants. KDADS runs a monthly report directly from the KMMS data warehouse. During the annual MCO contractual audit, the KDHE clinical team reviews a statistical sample of medical records for utilization review.
- **Qualified Provider enrollment**: KDHE contracts with Gainwell to enroll providers in KanCare and the MCOs to contract and credential service providers. KDHE provides oversight.
- **Execution of Medicaid provider agreements**: MCOs contract and credential with Medicaid service providers. KDHE provides oversight.
- **Establishment of Statewide Rate Methodology**: KDHE/KDADS use Optumas as a state contracted actuary.

**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:
The state's Community Mental Health Centers (CMHC) conduct waiver assessment for current and potential participants. Initial and annual assessments are completed by the CMHC.

KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines program eligibility before KDHE determines financial eligibility and submits through KDADS official operating system (KAMIS). KDADS Program reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on those approved and met LOC criteria. The 3160 designated program eligibility form is complete and sent on to the KDHE eligibility department for the financial determination. KDHE then notifies the MCO and CMHC of the final eligibility and if approved, the start date of waiver services.

The MCO and CMHC meet with the participant and participant's family at initially and then every 90 days to review the Person Centered Service Plan. The Person Centered Service Plan Team meet with the participant to review goals and the need for continued waiver services to meet their defined goals. These is determined through the CMHC's conducting a Level of care assessment annually. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. The participant's Annual LOC documents are uploaded by the CMHCs into KDADS KAMIS reporting system for KDADS review. The KDADS Quality Review Team reviews a sample of the CMHC’s reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver.

KDADS reviews and approves documentation for functional eligibility and the Single State Medicaid Agency (KDHE) approves financial eligibility. KDHE holds the contract for the Managed Care Organizations. KDHE hold regular quality assurance and oversight activities for the MCOs’. KDHE contracts with KFMC to perform EQRO functions.

KDADS oversees assessing entities in quarterly quality reviews.

KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines program eligibility before KDHE determines financial eligibility. KDADS Program Manager reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on the designated form for approval and sends it on to the KDHE eligibility department for the financial determination. Reevaluations: The CMHC’s upload the participant’s Annual LOC documents into KAMIS for KDADS review. If the participant no longer qualifies, the CMHC submits a 3161 to KDHE. KDHE sends a formal notice to participant that they are no longer eligible for the waiver.

KDADS Quality Review Team reviews a sample of the CMHC’s reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver. These documents include the Annual Evaluation of Level of Care Form.

The HCBS Quality Strategy ensures that the entities contracting with KDADS are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1915 (b) waiver, Kansas statutes and regulations, and related policies.

The CMHCs have quarterly reviews by the KDADS QA reviewers. A sample is pulled for each performance measure and reviews are conducted. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. Each quarter the KDADS QA reviewers review a sample of members to determine whether functional eligibility was completed according to the waiver requirements. When issues are found related to the member’s functional eligibility determination follow up and remediation is taken with the SED program manager and CMHC assessor.

KDHE Waiver Managers review and approve all quarterly reviews Performance Measure reports, 372s and Evidence Packages before submitting these reports to CMS.

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.

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
<th>Local Non-State Entity</th>
</tr>
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<tbody>
<tr>
<td>Participant waiver enrollment</td>
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<tr>
<td>Waiver enrollment managed against approved limits</td>
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<td>Waiver expenditures managed against approved levels</td>
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<td>Level of care evaluation</td>
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<td>Review of Participant service plans</td>
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<td>Prior authorization of waiver services</td>
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<td>Utilization management</td>
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<tr>
<td>Qualified provider enrollment</td>
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<td>Rules, policies, procedures and information development governing the waiver program</td>
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<td>Quality assurance and quality improvement activities</td>
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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:

PM 1: Number and percent of Quality Review reports generated by KDADS, the Operating
Agency, that were submitted to the State Medicaid Agency Numerator: Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency Denominator: Number of Quality Review reports

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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Data Aggregation and Analysis:

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- ✔ Continuously and Ongoing

Other Specify:  

Performance Measure:  
Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency  
Numerator: Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS  
Denominator: Total number of waiver amendments and renewals

Data Source *(Select one)*:  
Other  
If 'Other' is selected, specify:  
Presentation of waiver amendments and renewals  

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Other

07/05/2023
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**Performance Measure:**

Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency Numerator: Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency Number of waiver policy changes implemented by the Operating Agency

**Data Source** (Select one):

Other

If 'Other' is selected, specify:

Presentation of policy changes to KDHE

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07/05/2023
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### Performance Measure:
Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

- **Numerator:** Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
- **Denominator:** Number of Long-Term Care meetings

### Data Source (Select one):
- **Other**
  - If 'Other' is selected, specify:
  - **LTC meeting attendance record**

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### Application for 1915(c) HCBS Waiver: Draft KS.009.05.02 - Jan 01, 2024
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07/05/2023
### Data Aggregation and Analysis:

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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 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. Staff of all three MCOs engage with state staff to ensure strong understanding of Kansas’ waiver programs and the quality measures associated with each waiver program. The MCOs have begun to collect data regarding the waiver performance measures and reporting options. 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.

### 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 are tracked consistent with the statewide quality improvement strategy.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

### ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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<td>Other Specify:</td>
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</table>

### 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
- [x] Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State is planning the waiver amendment Summer 2022 to address performance measures across waivers. The State has been working with New Editions to develop these performance measures.

### 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:

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<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
<th>Maximum Age Limit</th>
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b. Additional Criteria. The state further specifies its target group(s) as follows:

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:
The MCO Care Coordinator in the person-centered planning process will help to identify community resources and services that are in line with the participant’s goals. The participant’s Service Plan is reviewed every 90 days or when the child's needs change, wraparound services are provided on an as needed basis throughout this process. A review of the participant's needs, goals, objectives, resources, preferences, participant's desired outcomes, and strengths are identified. At any time, the participant, their family, or the therapist may identify a need for a change in supportive services for the participant. As the participant approaches desired outcomes or is nearing the age limit of 22, a continuum of services will be identified by the participant, MCO and participants of the wraparound team. The MCO in collaboration with the local CMHC staff will link and access those identified services to the participant to achieve a successful transition.

Coordination between the CMHC’s programs for child/participant and community Behavior Health Services at large will occur to aid in the transition. When the participant is transitioning out of the SED Waiver due to maximum age the MCO in collaboration with the CMHC evaluates the participant for adult community based services and mental health supports. Transition planning for a participant may begin as early as necessary but should start at least by the annual review that occurs in the year prior to turning age 22. An individual who remains clinically eligible will continue to receive services until his/her 22nd birthday. If the participant meets the applicable criteria for another waiver then transition to that program will be supported by the MCO/CMHC using the approved methods in the waiver or program that is determined to best meet the participants needs.

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's cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:
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:

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<tr>
<td>Year 4</td>
<td>4900</td>
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<tr>
<td>Year 5</td>
<td>4900</td>
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</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Purposes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Military exception</td>
<td>5</td>
</tr>
</tbody>
</table>

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):*

<table>
<thead>
<tr>
<th>Military exception</th>
</tr>
</thead>
</table>

**Purpose** *(describe):*

The State reserves capacity for military participants and their immediate dependent family members who have been determined program eligible may bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established SED waiver criteria will be allowed to bypass the waitlist and access services.

The Operating Agency does not have a waiting list for the SED waiver. A waiting list is not anticipated to be put in place. If a waiting list should occur, entrance parameters would be defined at that time with input from stakeholders and providers. Entrance to the waiver is determined by clinical (functional) and financial eligibility with the State of Kansas currently enrolling all eligible participants. The State of Kansas has legislative authority to request increased capacity if the number of applicants exceeds the approved number of eligible.

**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:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>5</td>
</tr>
<tr>
<td>Year 2</td>
<td>5</td>
</tr>
<tr>
<td>Year 3</td>
<td>5</td>
</tr>
<tr>
<td>Year 4</td>
<td>5</td>
</tr>
<tr>
<td>Year 5</td>
<td>5</td>
</tr>
</tbody>
</table>
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:

The waiver provides for the entrance of all eligible persons. This is spelled out in KDADS Serious Emotionally Disturbance Policy.

Entry to the waiver is offered to individuals to the waiver as they apply for the waiver. Kansas has no waiting list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (select one):

- §1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (select one):

- No
- Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under
the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. Check all that apply:

<table>
<thead>
<tr>
<th>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income families with children as provided in §1931 of the Act</td>
</tr>
<tr>
<td>SSI recipients</td>
</tr>
<tr>
<td>Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121</td>
</tr>
<tr>
<td>Optional state supplement recipients</td>
</tr>
<tr>
<td>Optional categorically needy aged and/or disabled individuals who have income at:</td>
</tr>
<tr>
<td>Select one:</td>
</tr>
<tr>
<td>100% of the Federal poverty level (FPL)</td>
</tr>
<tr>
<td>% of FPL, which is lower than 100% of FPL.</td>
</tr>
<tr>
<td>Specify percentage: [ ]</td>
</tr>
<tr>
<td>Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)</td>
</tr>
<tr>
<td>Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>Medically needy in 209(b) States (42 CFR §435.330)</td>
</tr>
<tr>
<td>Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)</td>
</tr>
<tr>
<td>Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)</td>
</tr>
<tr>
<td>Specify:</td>
</tr>
</tbody>
</table>

Reasonable classification group of individuals up to age 22 who meet the income and resource requirements of AFDC covered under 42 CFR 435.222 defined as children up to age 22 who if not for the provision of HCBS waiver services would otherwise be institutionalized.

Parents and other caretaker relatives (42 CFR 435.110) and children (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:
A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)

- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage: [ ]

- A dollar amount which is lower than 300%.

Specify dollar amount: [ ]

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

- 100% of FPL

- % of FPL, which is lower than 100%.

Specify percentage amount: [ ]

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).
Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

- Use spousal post-eligibility rules under §1924 of the Act.
  
  (Complete Item B-5-b (SSI State) and Item B-5-d)

- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
  
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

- The following standard included under the state plan

  Select one:

  - SSI standard
  - Optional state supplement standard
  - Medically needy income standard
  - The special income level for institutionalized persons

  (select one):

  - 300% of the SSI Federal Benefit Rate (FBR)
  - A percentage of the FBR, which is less than 300%

    Specify the percentage:

  - A dollar amount which is less than 300%.

    Specify dollar amount:

  - A percentage of the Federal poverty level

    Specify percentage:

  - Other standard included under the state Plan

    Specify:
The following dollar amount

Specify dollar amount: [ ] If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: [ ] If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:
Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state’s approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

- **Other**

  Specify:

iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

   - a. Health insurance premiums, deductibles and co-insurance charges
   - b. Necessary medical or remedial care expenses recognized under state law but not covered under the state’s Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.

- **The state does not establish reasonable limits.**

- **The state establishes the following reasonable limits**

  Specify:

---

**Appendix B: Participant Access and Eligibility**

**B-5: Post-Eligibility Treatment of Income (3 of 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- **c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

**Appendix B: Participant Access and Eligibility**

**B-5: Post-Eligibility Treatment of Income (4 of 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- **d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

  The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the
contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level
  
  Specify percentage: ________________

- The following dollar amount:
  
  Specify dollar amount: ________________  If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:
  
  Specify formula:

- Other

  Specify:

  300% of SSI

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:
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.


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.


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.


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: [ ]
ii. **Frequency of services.** The state requires (select one):
- The provision of waiver services at least monthly
- Monthly monitoring of the individual when services are furnished on a less than monthly basis

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

---

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):
- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By a government agency under contract with the Medicaid agency.

*Specify the entity:*

---

- Other
  
  *Specify:*

---

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:

According K.S.A.(j) Qualified Mental Health Professional means a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health center, a licensed masters level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

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.
II. The applicant must have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria. Disorders include, those listed in the most current DSM or the International Classification of Diseases (ICD) equivalent; Disorders do not include DSM-V "V" codes; Disorders do not include substance abuse or dependence and developmental disorders unless such co-occurs with a diagnosable condition such as mental, behavioral, or emotional disorder of sufficient duration to meet the most current DSM diagnostic criteria.

The applicant must meet standard thresholds on the following assessments:

1. Child Behavior Checklist (CBCL) or the Adult Behavior Checklist (ABCL); AND

2. Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS) for children under five (5) years of age.

1. Qualifying on the CBCL/ABCL is completed by parent/guardian to assess behavioral and emotional problems:
   a. A qualifying score of 70 on any subscale of the Child Behavior Checklist (CBCL) for applicants less than 18 years of age,
   b. A CBCL exception may be granted by the State -if a score of 63-69 on any subscale, and based on other supporting forms by a qualified mental health practitioner with a clinical judgement of that child/youth's impending risk of Inpatient Psychiatric Hospitalization within the next month which that the guardians account doesn't reflect.
   c. A qualifying score of 70 on any subscale of the Adult Behavior Checklist (ABCL) for applicants older than 18 years of age.
   d. The CBCL or ABCL must be current. I. The assessment must provide information concerning the applicant's behavior during the previous six months from the date of clinical judgement.

2. Qualifying on the CAFAS:
   a. The qualifying score for the CAFAS is a total score of 100 or a score of 30 on two subscales,
   b. The CAFAS must be completed by a Qualified Mental Health Professional (QMHP),
   c. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) may be substituted for the CAFAS for children under five (5) years of age. The range of clinical scores on the PECFAS is the same as the CAFAS.
   d. There is no exception to the CAFAS requirement.
   e. The CAFAS must have been completed less than three months prior to the clinical eligibility date.

III. Risk of Inpatient Psychiatric Hospitalization

(a) As part of an applicant's initial clinical eligibility packet, a Qualified Mental Health Professional (QMHP) with a Community Mental Health Centers (CMHC) must include:
   i. An attestation/narrative of the applicant's risk of inpatient psychiatric hospitalization.
   ii. The attestation must be signed and dated by the QMHP, with their credential included.
   iii. The applicant's medical record must also include the completed initial clinical level of care packet containing the attestation/narrative of the applicant's risk of inpatient psychiatric hospitalization to demonstrate the need for a inpatient Psychiatric Hospitalization stay.

Annual Level of Care Criteria is assessed through re-administering the CAFAS or PECFAS assessment tool, as well as the clinical judgment of a qualified mental health provider that the child/youth are at risk of Inpatient Psychiatric Hospitalization and then KDADS SED Program manager or Program Eligibility Specialist reviews findings for continued program eligibility.

The Child & Adolescent Functional Assessment Scale (CAFAS) is a rating scale, which assesses a participant's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems. One of its primary purposes is to assign cases to the appropriate level of care. The CAFAS is organized into eight scales for rating the child: school/work, home, community, behavior towards others, moods and emotions, substance abuse, self-harm, and thinking. A total score is derived for which there are general interpretive guidelines.

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
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.

The Community Mental Health Center Screening Form is utilized to screen for a variety of intensive inpatient psychiatric services. The form includes information on presenting problem, risk factors, clinical impressions, and inpatient criteria. The form is not based on a standardized tool or assessment, but solely on the self-report of the participant or family and the clinical judgment of qualified mental health practitioner. The Community Mental Health Center Screening Form is the instrument used to assess for institutional level of care.

Kansas uses the initial clinical eligibility packet to determine level of care for the SED waiver. The initial clinical eligibility packet includes assessment information and the clinical impression of the qualified mental health professional, specifically a narrative summary of the clinical assessment and a narrative summary of the current evidence supporting the participants need for the level of care provided in an inpatient psychiatric hospital. In addition, the initial clinical eligibility packet includes the utilization of two normed and validated clinical assessments, the Child Behavior Checklist (CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS).

Kansas's initial clinical eligibility packet is a more stringent instrument based on nationally normed and validated clinical assessments. All participants receiving SED waiver services meet minimum scores in the clinical range on these standardized assessments (CBCL and CAFAS) and all participants receiving SED waiver services have a clinical need comparable to those served within inpatient psychiatric hospitals.

The State uses the Community Mental Health Center Screening Form to determine admission to a child’s state hospital alternative. These settings are inpatient, institutional alternatives to the state mental health hospitals. These institutional state hospital alternatives are used because of the age requirement for admission into state mental hospitals. The CMHC Screening Form reviews three criteria levels for admission in the state hospital alternative setting. These criteria include: Self-care failure/self-injury, diagnosis, and clinical needs. These criteria directly correlate to the measures used for the SED functional eligibility instrument. Given these co-relations the institutional instrument and functional eligibility instrument are directly 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:
KDADS Program staff members review each individual needs-assessment packet submitted by the assessing entity. Program staff review the individual needs assessment results on both the CAFAS and CBCL assessment and determine that the individual meets the LOC eligibility thresholds scores. The assessing entity enters the results of the from CAFAS and CBCL assessments which are uploaded and entered into the KDADS tracking system of record, for KDADS review and confirmation of accuracy. Program staff also review age, contact information of parents/guardians, DSM V diagnosis, and narrative of presenting factors that warrant the need for hospitalization without SED waiver services in order to confirm the assessor’s clinical judgement from the face-to-face presentation of symptoms of the child/youth. KDADS program staff also verify the assessment was performed by a QMHP who is credentialed by the CMHC. After the KDADS Program Manager reviews all the information listed above, they determine program eligibility. KDADS then submits the program eligibility status to the KDHE Eligibility Unit for KanCare Medicaid application financial consideration and final determination of eligibility for waiver services. KDHE sends the eligibility determination notice to the responsible party of the applicant of the child/youth’s eligibility status for the SED waiver. If not found eligible, the notice contains appeal rights. When an applicant is eligible, KDHE sends the completed ES-3160 form back to KDADS, the designated Managed Care Organization, and the CMHC.

The Reevaluation Process:
Individual needs assessments are determined by the QMHP through the CMHC. This consists of re-administering the CAFAS or PECFAS assessment tool, which also includes a face-to-face interview as well as the clinical judgement of a qualified mental health provider that the child/youth continue to be at risk of Inpatient Psychiatric Hospitalization. The QMHP uploads the reassessment of needs package into KDADS tracking system of record for review. This KAMIS based assessment will have all the required reassessment modules to capture program eligibility status, including the services utilized to avoid inpatient hospitalization. The KDADS Program Manager or Program Eligibility Specialist reviews findings to determine eligibility status. If the waiver participant is found ineligible, KDADS notifies the KDHE Eligibility Unit via an ES-3161, and KDHE notifies the individual with the same appeal rights as a new applicant who is denied waiver services.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):
- Every three months
- Every six months
- Every twelve months
- Other schedule
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (specify):

The provider that is responsible for performing annual assessments must upload assessment information into the State’s database. This ensures that all reevaluations are done in a timely manner and allows KDADS to identify and remediate any outstanding reevaluations.

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
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

\[
N = \text{Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services} \\
D = \text{Total number of enrolled waiver participants}
\]

Data Source (Select one):
Other
If ’Other’ is selected, specify:
Other-Operating Agency’s data systems/State Data System application and Managed Care Organizations (MCOs) encounter data

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07/05/2023
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07/05/2023
b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination

Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination

Denominator: Number of waiver participants who received Level of Care redeterminations

Data Source (Select one):

Record reviews, off-site

If ‘Other’ is selected, specify:

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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

\[
N = \text{Number of waiver participants whose Level of Care determinations used the approved screening tool}
\]

\[
D = \text{Number of waiver participants who had a Level of Care determination}
\]

Data Source (Select one):
Operating agency performance monitoring
If ‘Other’ is selected, specify:
Record reviews

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### Performance Measure:
Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor

- **Numerator:** Number of initial Level of Care (LOC) determinations made by a qualified assessor
- **Denominator:** Number of initial Level of Care determinations

### Data Source (Select one):
- Other
  - If 'Other' is selected, specify: 
    - Record reviews

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**Performance Measure:**
Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Numerator: Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Denominator: Number of initial Level of Care determinations

**Data Source** (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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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-up remediation as necessary. In addition, the performance of the functional contractor with Kansas will be monitored on an ongoing basis by the State and the MCOs to ensure compliance with the contract requirements. Additionally, KDADS Program Manager reviews the ICEP which includes the CAFAS and CBCL or Annual LOC for LOC evaluation for functional eligibility.

### b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.
These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

### ii. Remediation Data Aggregation

**Remediation-related Data Aggregation and Analysis (including trend identification)**

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**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ☐ No
- ☑ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State is receiving TA assistance to ensure all Waiver quality measures appropriately meet the intent of each assurance. The State is currently targeting 1/1/23 to have new/revised measures implemented. The State has included this timeline in the Waiver.

### 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:

1. informed of any feasible alternatives under the waiver; and
2. given the choice of either institutional or home and community-based services.

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible
alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Before the functional eligibility evaluation is conducted, as a part of the referral process the CMHC educates the individual on their choices of community-based programs as well as the institutional equivalent. The CMHC assessor documents the individuals' choice of Home and Community-based services on the eligibility communication form (E-3160) used by the state. In addition, during the Person-Centered Service Plan development process, the KanCare MCO selected by the participant informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the Person-Centered Plan document to note the choice.

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.

The MCO maintains all Service planning documentation in their records. The forms are maintained a minimum of three years.

Appendix B: Participant Access and Eligibility

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information.

The State of Kansas defines prevalent non-English languages as languages spoken by a 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 participant in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contract with KDADS and available statewide.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

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<td>Statutory Service</td>
<td>Short-Term Respite Care</td>
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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):**
- Attendant Care

**HCBS Taxonomy:**

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</table>
Attendant care for the SED waiver is provided to a child whose mental health disorder affects their activities of daily living. It is specialized in the way it is provided based on how the child’s therapist is working with the child. SED attendant care is designed to help the child cope with their mental illness and provide them with someone to help work through emotional disturbances caused by the mental health disorder. Attendant care on the SED waiver is designed to continue working on skills set by the QMHP or LMHP to help the child with their mental health diagnosis. The clinical supervision is necessary to ensure the correct skills are being utilized. The SED waiver allows children to continue to receive therapy services from providers other than therapists at the CMHC. The Contractor-Designated LMHP is a licensed mental health professional that is providing therapy services to a child on the SED waiver. The LMHP in these cases is not directly associated with the CMHC.”

Attendant care for the SED waiver is provided to a child whose mental health disorder affects their activities of daily living. It is specialized in the way it is provided based on how the child’s therapist is working with the child. SED attendant care is designed to reinforce techniques from the child’s primary therapist. SED attendant care is designed to help the child cope with their mental illness and provide them with someone to help work through emotional disturbances caused by the mental health disorder. Attendant care on the SED waiver is designed to continue working on skills set by the QMHP or LMHP to help the child with their mental health diagnosis. The clinical supervision is necessary to ensure the correct skills are being utilized. The SED waiver allows children to continue to receive therapy services from providers other than therapists at the CMHC. The service enables the waiver participant to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cueing so the participant performs task by him/herself. Such assistance most often relates to performance of Activities of Daily Living and Instrument Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. Services must be recommended by a wraparound team and must be intended to achieve the goals or objectives identified in the participant's Person-Centered Service Plan. All coordination must be documented in the waiver participant's medical record. Transportation is provided between the participant’s place or residence and other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this services. Kancare MCO's will be responsible for all other transportation needs for the waiver participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. There are no limits on Attendant Care hours. Services must be prior authorized. Participants must receive ongoing and regular clinical supervision by a person meeting the qualification of a Qualified Mental Health Professional and supervision shall be available at all times.

Services provided at a work site must not be job tasks oriented. Waiver funding may not be used to pay for special education and related services that are required to be included in a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Excludes services to waiver participants who is in an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual or developments disabilities, or institution for mental disease.

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:
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
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</tbody>
</table>

**Service Type:** Statutory Service  
**Service Name:** Attendant Care

**Provider Category:**  
**Agency**

**Provider Type:**  
Community Mental Health Center

**Provider Qualifications**

**License (specify):**

Attendant Care worker must have a high school diploma or equivalent and are supervised by the QMHP as defined by KSA 19-400. Attendant Care workers have additional training that is located on KS Train.

**Certificate (specify):**

Attendant Care workers have additional training that is located on KS Train up to 2 hours before providing direct care. The hours of training cover the Basics of Community Support Services for Youth.

**Other Standard (specify):**

Must be 18 years of age and at least 3 years older than the youth. Completion of state approved training according to the curriculum approved by the Operating Agency prior to providing the service.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

A Qualified Mental Health Professional and/or Licensed Mental Health Professional provides supervision and guidance to the attendant care worker who is providing direct services to the child or youth utilizing the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The CMHC, as an agency provider, verifies the qualifications of the attendant care performing the assigned task. The MCOs conduct an annual provider review via a shared contractor. KDADS verifies the MCO contractor reviews annually and these finding are also reviewed and verified by KDHE.

**Frequency of Verification:**

Annually
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:
Habilitation

Alternate Service Title (if any):
Independent Living/Skills Building

HCBS Taxonomy:

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<thead>
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<th>Category 1:</th>
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<td>04 Day Services</td>
<td>04020 day habilitation</td>
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<th>Sub-Category 4:</th>
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</table>

Independent Living/Skills Building services are designed to assist participants who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. Independent Living/Skills Building activities are provided in partnership with participants to help them arrange for the services they need to become employed, find transportation and housing, and continue their education. Services are individualized according to each participant's strengths, interests, skills, and goals as specified in the service plan. Independent Living/Skills Building activities should take place in the community. This service can be utilized to train and cue normal activities of daily living. Housekeeping, homemaking, or basic services solely for the convenience of the participant receiving Independent Living/Skills Building are not covered. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The following are examples of appropriate community settings rather than an all-inclusive list: a grocery store to teach the participant how to shop for food, a clothing store to teach the participant what type of clothing is appropriate for job interviews, an unemployment office to assist in seeking jobs or assist the participant in completing applications for jobs, apartment complexes to seek out housing opportunities, and laundromats to teach the participant how to wash clothing. This is not an all-inclusive list. Other appropriate activities can be provided in any other community setting as identified through the service plan process.

Transportation is provided between the participants place of residence and other services sites or places in the community. The cost of transportation is included in the rate paid to providers of this service. Children may begin accessing this service at age 14.

Independent Living/Skills Building does not duplicate any other Medicaid state plan service or service otherwise available to participants at no cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. There are no limits on Independent Living/Skills Building. Independent Living/Skills Building cannot be used to replace, supplement, or supplant education and related services that are included in a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

**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:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Independent Living/Skills Building

**Provider Category:**

<table>
<thead>
<tr>
<th>Agency</th>
</tr>
</thead>
</table>

**Provider Type:**

Community Mental Health Center

**Provider Qualifications**

**License** *(specify):*

The Transition Coordinator must have a high school diploma or equivalent. Must be 21 years of age. Completion of Independent Living/Skills Building training according to a curriculum approved by the Operating Agency prior to providing the service. Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. The State requires that all providers of SED waiver services undergo and pass a criminal background check with the Kansas Bureau of Investigation and Department of Children and Family Services child and adult registry as well as a motor vehicle check.

**Certificate** *(specify):*

Not applicable.

**Other Standard** *(specify):*
Individual provider must have a high school diploma or equivalent.

Must be 21 years of age.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Family Services child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Completion of Independent Living/Skills Building training according to a curriculum approved by the Operating Agency prior to providing the service.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

**Frequency of Verification:**

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):**

Short-Term Respite Care

**HCBS Taxonomy:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
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<td>09 Caregiver Support</td>
<td>09011 respite, out-of-home</td>
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</table>

<table>
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<tr>
<th>Category 2:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>09 Caregiver Support</td>
<td>09012 respite, in-home</td>
</tr>
</tbody>
</table>
Short-Term Respite Care provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. The service is designed to help meet the needs of the primary caregiver, as well as the identified participant. Normal activities of daily living are considered content of the service when providing respite care. These include support in the home, after school, or at night; transportation to and from school, medical appointments, or other community-based activities, or any combination of the above. The cost of transportation is included in the rate paid to providers of this services. Short-Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings. Other community settings include Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds. Short-Term Respite Services provided by or in an IMD are not covered. The service cannot be provided in a Youth Residential Center 1 or a Youth Residential Center 2. The participant must be present when providing Short-Term Respite Care.

Short-Term Respite Care may not be provided simultaneously with Professional Resource Family Care services and does not duplicate any other Medicaid state plan service, or service otherwise available to participants at no cost.

Foster care children and youth on the SED waiver will not be able to access short term respite care. This service is available to children and youth in foster care under the foster care contract.

This service cannot be provided in a Youth Residential Center 1 or a Youth Residential Center 2. Short term respite care is time limited and may not exceed 30 consecutive days. FFP may not be claimed for room and board when respite is provided in the participant’s home or place of residence.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

<table>
<thead>
<tr>
<th>Service Type: Statutory Service</th>
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</thead>
<tbody>
<tr>
<td>Service Name: Short-Term Respite Care</td>
</tr>
</tbody>
</table>

Provider Category:

Agency
Provider Type:

Community Mental Health Center

**Provider Qualifications**

**License (specify):**

Respite Care worker must have a high school diploma or equivalent and be supervised by the QMHP as defined by KSA 19-4001.

The home or facility must meet applicable Kansas Department of Children and Families licensure requirements in an overnight setting outside the family or relative's home.

**Certificate (specify):**

CPR.

Crisis Prevention/Management (example: CPI, Mandt, etc.).

**Other Standard (specify):**

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age.

Completion of Short-Term Respite Training according to the curriculum approved by the Operating Agency prior to providing the service.

First Aid.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

**Frequency of Verification:**

Annually

---

Appendix C: Participant Services

C-1/C-3: Service Specification

07/05/2023
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:**

Parent Support and Training

**HCBS Taxonomy:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
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<tbody>
<tr>
<td>10 Other Mental Health and Behavioral Services</td>
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<th>Category 2:</th>
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<tr>
<td>09 Caregiver Support</td>
<td>09020 caregiver counseling and/or training</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Category 3:</th>
<th>Sub-Category 3:</th>
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<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
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</table>
Parent Support and Training is designed to provide families of children who have been identified to have a serious emotional disturbance and in need of or at risk of more intensive level of care such as a state psychiatric hospitalization, psychiatric residential treatment facility treatment (PRTF), or brief hospitalization or crisis services the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Parent Support and Training can be provided anywhere in the community that is agreeable to the individual.

This is a training and support service necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the participant.

For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting.

1. Support, coaching and training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member.
2. This involves helping the families identify and use healthy coping strategies to decrease caregiver strain, improve relationships with family, peers and community members and increase social supports;
3. Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the participant in relation to their mental illness and treatment;
4. Development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the participant's symptom/behavior management;
5. Assist the family in understanding various requirements of the waiver or grant process, such as the crisis plan and service plan process;
6. Educational information and understanding on the participant’s medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the participant with mental illness while living in the community; provide information on supportive resources in the community;
7. Service must be intended to achieve the goals and/or objectives identified in the participant's Service Plan.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant’s functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community.

The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of supports through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication. Text messaging and e-mailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

Direct support can be provided through the virtual delivery of the service when all of the following requirements are met:

a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.

b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.

c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;

i. Participants must have an informed choice between in person or the virtual delivery of the service;

ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and

iii. Participants must affirmatively choose virtual delivery of the service over in-person supports.

e. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the
service must be used to support a participant to reach identified outcomes in the participant’s Person-Centered Plan;
f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including
start and end times.
g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and
Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical
Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant’s
protected health information.
h. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical
emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and
advise participants and their person-centered planning team regarding those policies that address:
i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant’s home), and
ensuring they are present during provision of virtual delivery of the service in case the participant experiences an
emergency; and processes for requesting such intervention if the participant experiences an emergency during
provision of virtual supports, including contacting 911 if necessary.
j. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a
service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
k. The provider must develop, maintain, and enforce written policies, approved by the state, which address:
i. Identifying whether the participant’s needs, including health and safety, can be addressed safely via virtual
delivery of the service.
ii. How the provider will ensure the participant’s rights of privacy, dignity and respect, and freedom from coercion
and restraint during virtual delivery of the service.
iii. How the provider will ensure the virtual delivery of the service meets applicable information security
standards; and
iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws
governing individuals’ right to privacy.
Instances, Instructions, and Limitations
Instances
Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered
virtually and the technology or device appropriate to support the virtual delivery of the service is available.
Instructions and Limitations
• The program participant’s person-centered service plan must indicate the use of the virtual delivery of the
service.
• The managed care organization must document the frequency of the virtual delivery of the service.
• Virtual delivery of a service shall be provided in real-time, not via a recording.
• When virtual delivery of the service is provided, the provider shall only render the service or support on a one-
on-one/individualized basis.
• The service provider shall be responsible for providing the device or technology required to support the virtual
delivery of the service. The Waiver program will not fund any costs associated with the provider’s virtual delivery
of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other
related expenses. These costs, in the virtual delivery of the service are part of the provider’s operating costs.

Technology and Devices
• Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver
participant.
• HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the
primary purpose of virtual delivery of a service.
• The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.
Community Integration and Participant’s Choice
• Where virtual delivery of a service is requested by the participant and authorized by the managed care
organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or
regimenting the participant from the greater community.
o The virtual delivery of the service shall be provided in the participant’s preferred setting.
o The participant’s choice for virtual delivery of a service shall be documented and included in their service plan.
o The participant shall be able to rescind their choice of virtual delivery of a service at any time.
When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the
participant’s service plan reflects the participant’s choice change.
o The managed care organization shall be responsible for ensuring that the provider is educating and informing the
participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
  - The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

Units and Delivery

- One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.
- The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
  - The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
- If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
- The participant shall have total control of the device, including turning it off or on.
- It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

Parent Support and Training does not duplicate any other Medicaid state plan service or service otherwise available to recipients at no cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on Parent Support and Training. Operationally, individuals receiving Parent Support Training do not simultaneously receive Professional Resource Family Care.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

<table>
<thead>
<tr>
<th>Service Type: Other Service</th>
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</thead>
<tbody>
<tr>
<td>Service Name: Parent Support and Training</td>
</tr>
</tbody>
</table>

Provider Category:

- Agency

Provider Type:

- Community Mental Health Center

Provider Qualifications

07/05/2023
License (specify):

Parent Support Specialist must have a high school diploma or equivalent and are supervised by the QMHP as defined by KSA 19-4001. Must be 21 years of age. Kansas Train provides an online Parent Support and Training in addition to the individual CMHC training that is provided for all Parent Support Specialists.

Certificate (specify):

Not applicable.

Other Standard (specify):

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age. Preference is given to Parents or caregivers of children with SED.

Completion of Parent Support Training according to a curriculum approved by the Operating Agency within one year of hire. Preference is given to Parents or caregivers of children with SED.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Peer to Peer provider must be associated with the CMHC.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor’s reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

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:

Professional Resource Family Care
Professional Resource Family Care is intended to provide intensive supportive resources for the participant and his or her family. This service offers intensive family-based support for the participant's family through the utilization of a co-parenting approach provided to the participant in a surrogate family setting. The goal is to support the participant and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. This service is provided in a licensed foster care home outside of the family home.

During the time the professional resource family is supporting the participant, there is regular contact with the family to prepare for the participant's return and his or her ongoing needs as part of the family. It is expected that the participant, family, and the professional resource family are integral members of the participants individual treatment team.

Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this services.

Professional Resource Family Care can be provided anywhere in the community that is agreeable to the individual.

Professional Resource Family Care may not be provided simultaneously with Short-Term Respite Care and does not duplicate any other Medicaid state plan service or service otherwise available to participants at no cost.

FFP is not claimed for the cost of room & board. Waiver funds are not available to pay for maintenance (including room and board) and supervision of children who are under the state’s custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs associated with maintenance and supervision of these children are considered a state obligation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service must be delivered in a licensed foster home.
Foster care children and youth on the SED waiver will not be able to access Professional Resource Family Care.
This service is available to foster care children and is named "Therapeutic Foster Care" under the foster care contract.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Professional Resource Family Care

Provider Category:
Agency

Provider Type:
Community Mental Health Center

Provider Qualifications

License (specify):
Professional Resource Family care must have a high school diploma or equivalent and are supervised by the QMHP as defined by KSA 19-4001. Must be 21 years of age.

Family Home Setting licensed by Kansas Department of Children and Families. Kansas Train provides additional online training in addition to individual CMHC training provided to Professional Resource Family Care Staff. CMHC orientation training includes, CPR, First Aid and nationally recognized CI training.

Certificate (specify):
First Aid.

Crisis Prevention/Management (Example: CPI, Mandt, etc.).

Other Standard (specify):
Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional and are supervised by the QMHP as defined by KSA 19-4001. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:
The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor’s reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:
Annually

07/05/2023
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:

Wraparound Facilitation

HCBS Taxonomy:

Category 1: 01 Case Management
Sub-Category 1: 01010 case management

Category 2:
Sub-Category 2:

Category 3:
Sub-Category 3:

Service Definition (Scope):

Category 4:
Sub-Category 4:
Wraparound facilitation is a mental health professional employed by the CMHC. Facilitators will be certified after completion of the specialized training on Kansas Train in the wraparound facilitation. The training is over twelve hours and 80 percent comprehension of the course objectives would have to be met before certification is awarded. Wraparound facilitation is used to bring the managed care organization, participant, family and community participants together to discuss community-based services and develop an individualized Person-Centered Service Plan.

The function of the wraparound facilitator is to form the wraparound team consisting of the participant’s family, extended family, other community members involved with the participant’s daily life, and the participant’s chosen MCO, for the purpose of updating the community-based person-centered Service Plan. This includes working with the participant’s family to identify who should be involved in the wraparound team and assembly of the wraparound team when subsequent Service Plan review and revision is needed, at minimum yearly to review the Service Plan and more frequently when changes in the participant’s circumstances warrant changes in the Service Plan. The wraparound facilitator will emphasize building collaboration and ongoing coordination among the parents or caregivers, family participants, service providers, MCO care coordinator, and other formal and informal community resources identified by the family. The wraparound facilitator will promote flexibility to ensure appropriate and effective service delivery to the participant and parents or caregivers. The wraparound facilitator provides ongoing wraparound services through the participants time on the SED waiver. Facilitators will be certified after completion of specialized training on Kansas Train in the wraparound philosophy, waiver rules and processes, waiver eligibility and associated paperwork, structure of the wraparound team, and wraparound meeting facilitation. While they may not be part of the team, wraparound facilitators are supervised by the CMHC agency’s QMHP. The WAF follows waiver language as specified.

Virtual Delivery of a service shall mean the provision of supports through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication. Text messaging and e-mailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

Direct support can be provided through the virtual delivery of the service when all of the following requirements are met:

a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
   i. Participants must have an informed choice between in person or the virtual delivery of the service;
   ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
   iii. Participants must affirmatively choose virtual delivery of the service over in-person supports.

e. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant’s Person-Centered Plan;
f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant’s protected health information.
h. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
   i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant’s home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.
   i. The virtual supports meets all federal and State requirements, policies, guidance, and regulations.
j. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.

k. The provider must develop, maintain, and enforce written policies, approved by the state, which address:
   i. Identifying whether the participant’s needs, including health and safety, can be addressed safely via virtual delivery of the service.
   ii. How the provider will ensure the participant’s rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
   iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals’ right to privacy.

Instances, Instructions, and Limitations

Instances
Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations
• The program participant’s person-centered service plan must indicate the use of the virtual delivery of the service.
• The managed care organization must document the frequency of the virtual delivery of the service.
• Virtual delivery of a service shall be provided in real-time, not via a recording.
• When virtual delivery of the service is provided, the provider shall only render the service or support on a one-on-one/individualized basis.
• The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider’s virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider’s operating costs.

Technology and Devices
• Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
• HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
• The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant’s Choice
• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
  o The virtual delivery of the service shall be provided in the participant’s preferred setting.
  o The participant’s choice for virtual delivery of a service shall be documented and included in their service plan.
  o The participant shall be able to rescind their choice of virtual delivery of a service at any time.
    When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant’s service plan reflects the participant’s choice change.
  o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

Training Requirement
• Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
  o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

Units and Delivery
• One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.
• The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.

- If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
- The participant shall have total control of the device, including turning it off or on.
- It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There are no limits on wraparound facilitation. The wraparound facilitator follows waiver language as specified. Wraparound facilitation cannot duplicate any services provided by targeted case management. TCM and Wrap Around Facilitator can play dual roles as both positions due to the rural nature of the State of Kansas.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed (X)

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
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<tr>
<th>Provider Category</th>
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<tbody>
<tr>
<td>Agency</td>
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</tbody>
</table>

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Wraparound Facilitation

Provider Category: Agency
Provider Type: Community Mental Health Center

Provider Qualifications
License (specify):

The wraparound facilitator must have at least a bachelor's degree or be equivalently qualified by work experience or a combination of work experience in the human services filed and education with one year of experience substituting for one year of education. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Certificate (specify):

Not applicable.

Other Standard (specify):
Individual providers must have at least a bachelor’s degree or be equivalently qualified by work experience or a combination of work experience in the human services filed and education with one year of experience substituting for one year of education.

Completion of Wraparound Facilitation training curriculum as approved by the Operating Agency prior to the delivery of service.

Pass a Kansas Bureau of Investigation background check, the DCF child and adult abuse registry checks, and motor vehicle screens.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor’s reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):

- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.
- As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:
Case management services for this waiver will continue to be provided by the community mental health centers (CMHC) across Kansas, who have clinical and programmatic expertise and experience regarding the needs of people who use this waiver, in collaboration with the care managers at the KanCare MCOs to address the needs of each waiver participant. CMHC Target Case Manager (TCM) assist individuals with access to medical, social, educational and other services outside the waiver. Wraparound Facilitation through a waiver service is provided in addition to targeted case management. TCM and Wrap Around Facilitator can play dual roles as both positions due to the rural nature of the State of Kansas, but are not allowed to bill for TCM when providing wrap around facilitation services. The MCO’s must approve all service plans and services listed in the person-centered service plan prior to a CMHC providing services to a youth and are present at the wrap around facilitation meetings.

The Health Action Plan (HAP) is the center piece of the One Care Kansas (OCK) program and for all OCK services delivered in the program. The HAP coordinates and integrates all clinical and non-clinical health care related to the member’s needs and services. The HAP does not replace any specific treatment plans or person-centered plans already required, such as HCBS person-centered service plans. It is designed to capture information that can be shared with all providers involved in serving the member. The HAP assigns specific responsibilities to the OCK provider and the OCK member related to the member’s health goals. The HAP captures whether there is a HCBS waiver service plan in place, and the type of waiver service plan. The waiver participant would not receive TCM through the Mental Health Center if they were enrolled in OneCare Kansas, who provides the Health Action Plan.

All OCK providers must employ sufficient and qualified staff to meet the member’s needs. In most cases, the MCO Care Coordinator will coordinate and write the HCBS person-centered support plan, and other TCM functions. The OCK Care Coordinator facilitates the development and maintenance of the HAP.

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):

In accordance with the Background check policy, background checks will be completed every two years. The State requires that all providers of SED waiver services undergo a criminal background check with the Kansas Bureau of Investigation and motor vehicle check. The Operating Agency interviews the Human Resources Director at the CMHC to determine whether the mandatory investigations have been conducted. The Operating Agency reviews the CMHC personnel files to ensure the results of the mandatory investigations are on file with the CMHC. eProvider files are reviewed by a joint MCO contractor annually. KDADS completes a sample of the MCO’s Contractor's files annually. KDHE reviews KDADS review of the provider files annually. This is review is completed by the joint MCO contractor who pulls a sample of each provider's employees for review annually.

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):

In accordance with the Background check policy, background checks will be completed every two years. The State requires that all providers of SED waiver services undergo a criminal background check with the Kansas Bureau of Investigation and motor vehicle check. The MCO contractor completes the sample review annually for each CMCH contactor to assure compliance with the background check policy.

Each provider is responsible for conducting the screening against the registry in accordance with HCBS Background Check Policy. Per the policy, these background checks are completed every two years. The MCO contractor conducts a sample pull annually to review of compliance for background check policy. KDADS quality assurance team reviews the contractors review to be sure the contractor's review is in compliance with the HCBS Background Check Policy.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.

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.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

In 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 the providers that support HCBS waiver members have had focused discussions with State staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to quality 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 has been made available via State and MCO websites.

All providers submit the required application, background check/screening, and required program specific documentation to the Kansas Medical Assistance Program (KMAP) at the time of enrollment. All applications are reviewed and processed in the order that they are received, usually within forty-five (45) days of application submission date provided a complete application is received. Providers have a portal at https://portal.kmap-state-ks.us/PublicPage/Public/ProviderManualsto gather information regarding requirements and procedures to qualify. KMAP processes a clean and accurate application in 5 business days. As soon as the application is approved, the MCOS will be able to access the enrollment application and all associated attachments in their portals.

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**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

07/05/2023
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 new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services

\[
N = \text{Number of new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services}
\]

\[
D = \text{Number of all new licensed/certified waiver providers}
\]

Data Source (Select one):
Other
If 'Other' is selected, specify:
KanCare Managed Care Organization (MCO) reports and record reviews

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Other Specify:

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### Performance Measure:

Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards

\[
N = \text{Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards}
\]

\[
D = \text{Number of enrolled licensed/certified waiver providers}
\]

---

### Data Source (Select one):

07/05/2023
Other

If ‘Other’ is selected, specify:
Managed Care Organization (MCO) reports and record reviews

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✗ Other

Specify:
KanCare Managed Care Organizations (MCOs)

✗ Annually

Stratified
Describe Group:
Proportionate by MCO

✗ Continuously and Ongoing

Other
Specify:

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<td>× Continuously and Ongoing</td>
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Other
Specify:

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services

\[
\begin{align*}
N &= \text{Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services} \\
D &= \text{Number of all new non-licensed/non-certified providers}
\end{align*}
\]

**Data Source (Select one):**

Other
If ‘Other’ is selected, specify:

Managed Care Organization (MCO) reports and record reviews

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### Performance Measure:

Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements

\[
N = \text{Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements}
D = \text{Number of enrolled non-licensed/non-certified providers}
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**Data Source** (Select one):

**Other**

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**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

- **Numerator:**
- **Denominator:** Number of active providers

**Data Source (Select one):**

Record reviews, off-site

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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.

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.

   Data analysis is completed and remediated for any assurance or sub-assurance less than 100%. KDADS staff will notify the MCO of areas below 100% with details of each finding. KDADS staff will notify the MCO if a any findings are below 87%, those that fall below 87% are required to also include a quality improvement project. The MCO will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.

   Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.

   Findings or concerns on a specific case identified through the review by Quality Management System (QMS) will be entered in Quality Review Tracker (QRT). Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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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.*

KDADS has proposed a statewide transition plan for residential and non-residential settings in compliance with federal HCBS requirements, upon approval from CMS.

Please see attachment 2 for the HCBS-SED Transition and statewide Transition plan.

### Appendix D: Participant-Centered Planning and Service Delivery

**D-1: Service Plan Development (1 of 8)**

**State Participant-Centered Service Plan Title:**

Person Centered Service Plan
a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):

- Registered nurse, licensed to practice in the state
- Licensed practical or vocational nurse, acting within the scope of practice under state law
- Licensed physician (M.D. or D.O)
- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker
  Specify qualifications:

- Other
  Specify the individuals and their qualifications:

The MCO service coordinators shall have experience that is appropriate to the Member’s health care needs and shall perform activities within their scope of practice in accordance with applicable licensing/credentialing rules. The MCO has the flexibility to determine the service coordinator qualifications for populations not specifically listed here. Service coordinators working with specific populations shall have specific qualifications. MCOS and community service coordinators serving Members who are in multiple population groups, such as youth in foster care who are enrolled on a HCBS Waiver, shall be assigned service coordinator most appropriate for the Member’s needs and have experience working with the populations to be served. At minimum qualifications shall include:

A. For Members with a LTSS need, MCO and community service coordinators shall:
   1. Have at least a bachelor’s degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN).
   2. Have at least one (1) year of experience working with individuals with long-term care needs, and if working with a specific Waiver population (e.g. IDD, TBI or Frail Elderly [FE]), at least one (1) years’ experience working directly with that population. Fulltime experience in the field of developmental disabilities services may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college for service coordinators working with individuals with IDD. Additionally, community service coordinators providing services to individuals with IDD must meets qualifications described in K.A.R. 30-63-32-Article 63.
   3. Comply with additional qualifications as described in the State’s HCBS Waivers included in Attachment C of this RFP.

B. For Members with a Behavioral Health need, CONTRACTOR(S) and community service coordinators shall:
   1. Have at least a bachelor’s degree in social work, nursing, rehabilitation, psychology or related health and human services area, or be a RN.
   2. Have at least one (1) year of experience working with individuals with Behavioral Health needs and receive training in trauma informed care.
Appendix D: Participant-Centered Planning and Service Delivery

D-I: 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 below safeguards to mitigate and address the potential problems that may arise when the individual’s HCBS provider, or an entity with an interest in or employed by a provider of HCBS, performs service plan development/case management was performed by the CMHC. The only organizations developing Person Center Service Plan are the Managed Care Organizations, even in rural areas of Kansas. The State agency is aware that the safeguards are addressed to be sure the following are met.
  a. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
  b. Direct oversight of the process or periodic evaluation by a state agency;
  c. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
  d. Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

An opportunity for the participant to dispute the state’s assertion that there is not another entity or individual that is not that individual’s provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Appendix D: Participant-Centered Planning and Service Delivery

D-I: 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.
The MCO providers 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 person center service plan development process. The MCO provides both the choice regarding services and services in the community vs. institutional based services as well as a choice of services. The Wraparound Facilitator forms the wraparound team consisting of the participant’s family or extended family or legal representative, other community members involved with the participant’s daily life, and the MCO service coordinator for the purpose of developing the community-based, Person Centered Service Plan. This includes the MCO and wrap around facilitator working with the participant’s family to identify who should be involved in the wraparound team. The responsibility of notifying all parties authorized by the participant of the date/time/ location of the PCSP meeting. Wrap around facilitator will assemble the wraparound team when subsequent Person Centered Service Plan review and revision is needed by the family and MCO or CMHC. There are ongoing 90 day reviews with families and at minimum, a yearly review the Person Centered Service Plan and more frequently when changes in the participant’s circumstances warrant changes in such plan.

The State has developed a Provisional Plan of Care process. It is a provisional plan of care which is developed at the time of care by the level of care assessor. The assessor uses the PPOC form to determine at least one waiver service a month that will qualify them for wavier needed services. The PPOC will be valid up to the point where the Person Center Support Plans are in place. On average, a PPOC may be into effect up to 30 days.

Then the PII is gathered by the MCO's with the potential waiver participant and their parent(s) and legal guardian. The MCO and the CMHC meet together with the participant and parent(s) to develop the Person Centered Service Plan. The Person Center Service plan process is discussed in the section above more in depth.

In addition to the initial plan, the State conducts a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the HCBS Performance Measures in the waiver. The Service Plan audit review is based off of statistically significant sample of the waiver population. The State has a continual quality review process for the HCBS Performance Measures, which includes a review of the participant Service Plan. Continuous feedback is given to the Medicaid Agency and Operating Agency, in addition to the MCOs regarding compliance related to the HCBS Performance Measures. KDHE performs MCO contract reviews annually and samples service plans in the contract review.

The State utilizes a statistically significant sampling methodology, that is specified in the HCBS waiver. The KDADS Quality Management Specialists conduct a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the Performance Measures listed in the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
The Wraparound Facilitator coordinates a Wraparound Meeting that is comprised of all identified parties of the participant’s choosing to develop the Person-Centered Service Plan. The waiver participant and family and/or legal guardian presence is required at the wrap around facilitation meeting. This meeting includes the participant's chosen MCO. The MCO Service Coordinator, and the CMHC Wraparound Facilitator are responsible for providing information about the all waiver and community based services that are available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant. The MCO, or their designee, will complete a needs assessment for the participant within 14 days and must address physical, behavioral and functional needs in the Person-Centered Service Plan that identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant will complete a Participant Interest Inventory (PII). The PII is a Person Centered Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Person Centered Service Plan meeting and will use the PII to help design the Person Centered Service Plan. The PSCP includes the scope, duration and amount of the authorized services for the HCBS participant. Participants are given free choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). The MCO Service Coordinator assists the participant with accessing information and supports from the participant's chosen provider. The MCO Service Coordinator is ultimately responsible for the Person Center Service Plan developments and updates.

The Person Centered Service Plan will be updated at the minimum of yearly and more frequently when changes in the participant’s circumstances warrant changes in the Service Plan or requested by the participant and/or family. The individual’s preference and choice of location is the primary determinant of meeting times. The MCO care coordinator provides a list of services that includes explanation of those services to the family at the time of Person Centered Service Plan development. CMHC is present at the times as part of the team to assist families and provide additional information to them regarding services in their specific county and surrounding area that can be of accessed quickly to aid in the situation immediately and long term. The MCO informs the participant about available services under the waiver at the Wraparound Meeting. All participants, including the legal guardian shall sign and date the Person-Centered Service Plan document signature page. All participants in the meeting, including the providers and the participant/guardian must sign off on the Person Center Service Plan.

Each service provider who will participate in the delivery of services shall sign a statement of understanding and consent to deliver the applicable services included in the Person-Centered Service Plan. The MCO shall coordinate obtaining provider signatures.

b) Provider signature does not constitute approval or denial of the Person-Centered Service Plan. Provider signatures indicate an understanding of the Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established in the Person-Centered Service Plan.

2. The participant may request that their primary or specialty care providers sign their plan, if this request is made, the MCO Care Coordinator is responsible to obtain signature from these providers.

a) In the event the provider originally selected refuses to sign a statement of agreement, the MCO Care Coordinator shall provide education to the participant that services on the plan cannot be provided by a Provider who is unwilling to sign the plan.

b) The MCO Care Coordinator shall obtain another provider choice from the individual.

3. In the event the only willing provider of HCBS services refuses to sign the Person-Centered Service Plan, the MCO must obtain signed documentation from the party that they refuse to sign the plan and the MCO Care Coordinator shall notify the applicable HCBS Program Manager, in writing, of this refusal. MCOs shall proceed with services for providers who have signed the Person-Centered Service Plan.

4. When interim changes are made to a participant’s Person-Centered Service Plan that MCO Care Coordinator must also obtain a signature from the impacted service providers.

5. Providers who fail to sign a statement of agreement will not be paid for services provided prior to MCO receipt of a signed statement from the provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan
development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each MCO completes a health risk assessment and a needs assessment, annually, to determine needed services for the participant. Each MCO also trains their staff on the person-center planning progress using the Lifecourse Model. Each Person-Centered Service Plan includes a Back-up Plan which outlines how the participant's needs will be addressed should there be an emergency or absence of a caregiver.

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.

Participants will have free choice of providers within the KanCare structure and may change providers as often as desired. Participants on the SED waiver may receive waiver services at the CMHC, but are not required to utilize a CMHC in an identified geographical area. When a participant becomes eligible for the SED Waiver and is already established with a therapist who is not a member of the network, the CMHC is required to make every effort to arrange for the participant to continue with the same provider if the participant so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a participant needs a specialized service that is not available through the network, the assigned managed care organization will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, participants will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. This information is provided in the KanCare health plan's member handbooks which are given to participants upon enrollment in the waiver. Member handbooks are also available on the KanCare health plan websites.

KanCare health plans lists all providers in their immediate area and surrounding counties that are accessible when carrying out their individualized Person Center Service Plan. MCOs' integrate all the behavioral and physical health services into the Service Plan. It is the MCO's responsibility to coordinate all State Plan and waiver services for their members.

**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 State has developed a Provisional Plan of Care process. It is a provisional plan of care which is developed at the time of care by the level of care assessor. The assessor uses the PPOC form to determine at least one waiver service a month that will qualify them for waiver needed services. Then the PII is gathered by the MCO's with the potential waiver participant and their parent(s) and legal guardian. Next the MCO and the CMHC meet together with the participant and parent(s) to develop the Person Centered Service Plan. The Person Center Service plan process is discussed in a different section in depth.

In addition to the initial plan, the State conducts a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the HCBS Performance Measures in the waiver. The Service Plan audit review is based off of statistically significant sample of the waiver population. The State has a continual quality review process for the HCBS Performance Measures, which includes a review of the participant Service Plan. Continuous feedback is given to the Medicaid Agency and Operating Agency, in addition to the MCOs regarding compliance related to the HCBS Performance Measures. KDHE performs MCO contract reviews annually and samples service plans in the contract review.

The State utilizes a statistically significant sampling methodology, that is specified in the HCBS waiver. The KDADS Quality Management Specialists conduct a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the Performance Measures listed in the waiver.

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:

The Eligibility Specialist maintains copies of the original FEI, freedom of choice forms, and the Rights and Responsibilities forms. The KanCare MCOs maintain the copies of the above mentioned information as well as any additional forms such as; the child/family strengthens and needs assessment, individualized behavioral program and Service Plan, detail progress notes, etc., In the child’s case file.

Copies are maintained for a minimum period of 3 years as required by 45 CFR 74.53

Appendix D: Participant-Centered Planning and Service Delivery

07/05/2023
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 three KanCare contracting managed care organizations are responsible for monitoring the implementation of Service Plans that were developed as a partnership between the participant and the MCO and for ensuring the health and welfare of the participant with input from the SED 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 Plans 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;
- Services meet participant’s needs;
- Liabilities with self-direction (if applicable)/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 plans of care. CMHC are providing information and performing the initial level of care assessments and send their findings to KDADS for program eligibility determination.

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.
- The Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually.

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 requiring remediation are reported to the MCO and waiver provider for prompt follow-up and feedback. Related information is reported to the SED 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 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.

The monitoring methods are a desk review of the Service Plans provided by the MCO’s as assigned during quarterly reviews. KDADS Quality Review Team reviews service plans as part of the quarterly performance measure review, and possible insincere ALs as part of the review process, and KDADS has a system in place to report that to appropriate personnel. The sample is statistically significant based off of approved waiver standards. The survey includes questions regarding current services and the individuals/guardians experience with HCBS services and the waiver. The KanCare MCOs maintain the copies of the above mentioned information as well as any additional forms such as; the child/family strengthens and needs assessment, individualized behavioral program and Service Plan, detail progress notes, etc., In the child’s case file. Copies are maintained for a minimum period of 3 years as required by 45 CFR 74.53 KDHE has MOC’s annual contract reviews; reviewing a sample of service plans.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:
Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans address participants' goals
Numerator: Number of waiver participants whose service plans address participants' goals
Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

Record reviews

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07/05/2023
Performance Measure:
PM 2: Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Numerator: 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

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Describe Group:  
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Specify:
KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency

× Annually
Continuously and Ongoing
Other
Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address health and safety risk factors
Numerator: Number of waiver participants whose service plans address health and safety risk factors
Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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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
For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver Numerator: Number of waiver participants whose service plans were developed according to the processes in the approved waiver Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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Performance Measure:
Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan KDADS HCBS Quality Review Report Numerator: Number of waiver participants (or their representatives) who were present and involved in the development of their service plan Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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c. **Sub-assurance**: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s 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:**

Numerator: Number of service plans reviewed before the waiver participant's annual redetermination date

Denominator: Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):

- Other

If ‘Other’ is selected, specify:

**Record reviews**

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**Performance Measure:**

Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change

Numerator: Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change

Denominator: Number of waiver participants whose service plans were reviewed

**Data Source (Select one):**

Record reviews, off-site

If ‘Other’ is selected, specify:

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**Performance Measure:**
Number and percent of service plans reviewed at least every 90 days

**Numerator:**
Number of service plans reviewed at least every 90 days

**Denominator:**
Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):
- Record reviews, off-site
  - If ‘Other’ is selected, specify:

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Confidence Interval = 95/5
d. **Sub-assurance**: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan

- **Numerator**: Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
- **Denominator**: Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):

- Record reviews, off-site

If ‘Other’ is selected, specify:

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<td>☐ Sub-State Entity</td>
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Performance Measure:
Number and percent of survey respondents who reported receiving all services as specified in their service plan
Numerator: Number of survey respondents who reported receiving all services as specified in their service plan
Denominator: Number of waiver participants interviewed by QMS staff

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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<td>Sub-State Entity</td>
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Continuous and Ongoing

Other Specify:

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 services

\[ N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver services} \]

\[ D = \text{Number of waiver participants whose files are reviewed for the documentation} \]

Data Source (Select one):

Other

If ‘Other’ is selected, specify:
### Record Reviews

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**Performance Measure:**
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver service providers Denominator: Number of waiver participants whose service plans were reviewed

**Data Source** (Select one): Record reviews, off-site
If ‘Other’ is selected, specify:

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Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative

Numerator: Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services
Denominator: Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:
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Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Numerator: Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Denominator: Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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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. As the KanCare program has been operationalized, staff of the three plans have been engaged with state staff to ensure strong understanding of Kansas’ waiver programs and the quality measures associated with each waiver program. The role of the MCOs is collecting and reporting data regarding the waiver performance measures has evolved, with increasing responsibility as the MCOs have had greater understanding of the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

   State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

   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)**

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07/05/2023
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.
Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.
Appendix E: Participant Direction of Services
   E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
   E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
   E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
   E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
   E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services
   E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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 Community Mental Health Centers (CMHC) conduct level of care determination. KDADS provides the program eligibility review. KDHE provides the financial eligibility review. Decisions made by the state are subject to state fair hearing review, and notice of the right and related process is provided at the time of the assessment.

- HCBS eligibility decision: Department of Health Care Finance (DHCF) makes decisions regarding HCBS waiver eligibility. If an HCBS participant loses eligibility for HCBS waiver services, KDHE sends the notice of action. The language regarding the member’s opportunity to request a fair hearing is in DHCF’s notice. Those notices are generated by KEES. HCBS service decision: The MCOs make decisions regarding HCBS waiver services. If an MCO reduces or terminates HCBS services, the MCOs issue the notice of adverse benefit determination (formerly called a notice of action). The language regarding a member’s opportunity to request a fair hearing is in that notice. The same information is also in each MCO’s Member Handbook. The notices are generated by each MCO’s notice generation system.

Each MCO provides a Member Handbook to each member which includes Fair Hearing Rights. The State reviews and approves the MCO Member Manuals to assure all information complies with the Fair Hearing process. HCBS eligibility decision: KDHE makes decisions regarding HCBS waiver eligibility. If an HCBS member loses eligibility for HCBS waiver services, DHCF sends the notice of action. The language regarding the member’s opportunity to request a fair hearing is in DHCF’s notice. Those notices are generated by KEES. HCBS service decision: The MCOs make decisions regarding HCBS waiver services. If an MCO reduces or terminates HCBS services, the MCOs issue the notice of adverse benefit determination (formerly called a notice of action). The language regarding a member’s opportunity to request a fair hearing is in that notice. The same information is also in each MCO’s Member Handbook. The notices are generated by each MCO’s notice generation system. The participant is informed via a Notice of Action from the MCO for an adverse action such as a service reduction. For an adverse action notice by the MCO there is a 60 plus window to appeal the decision before services are reduced or discontinued. KDHE will send a notice of action for closure of a participant’s services. HCBS eligibility decision: DHCF makes decisions regarding HCBS waiver eligibility. If an HCBS member loses eligibility for HCBS waiver services, DHCF sends the notice of action. The language regarding the member’s opportunity to request a fair hearing is in DHCF’s notice. Those notices are generated by KEES. HCBS service decision: The MCOs make decisions regarding HCBS waiver services. If an MCO reduces or terminates HCBS services, the MCOs issue the notice of adverse benefit determination (formerly called a notice of action). The language regarding a member’s opportunity to request a fair hearing is in that notice. The same information is also in each MCO’s Member Handbook. The notices are generated by each MCO’s notice generation system.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply
- Yes. The state operates an additional dispute resolution process

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process. State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*
b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. Participants have the right to submit grievances or appeals to their assigned managed care organization. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), requires the managed care organizations to operate a member grievance and appeal system consistent with federal regulations and Attachment D of the State’s contract with CMS. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1. KanCare members are informed that filing an appeal with the MCO is a prerequisite for a Fair Hearing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are part of the State’s fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State’s fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. The fiscal agent team escalates any grievance prior to the 3-occurrence timeframe based on the severity of the grievance. Through the escalation processes the fiscal agent team contacts KDADS, KDHE or the appropriate local authority who have access to this information at any time to ensure the member’s safety and wellbeing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time.

Participants who are not part of the Kancare program are part of the State’s fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State’s fiscal agent. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager, or by the Ombudsman's office.

Complaints are received in the Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately.

Grievance Unit must make contact related to a grievance within 3 business days. If the situation is urgent, the grievance staff make contact immediately. The grievance is required to be resolved within 30 calendar days.

As part of its regulatory role to educate participants regarding their rights and responsibilities.

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).
Reporting KDADS defined adverse incident requirements:

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident. The incident is reported to KDADS staff into AIRS include Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusion, and Restrictive interventions. Additionally, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110. These acts include all use of restraints, seclusion and restrictive intervention.

Identification of the individuals/entities that must report critical events and incidents:

The Kansas statutes K.S.A. 39-1431 and K.S.A. 38-2223 identify mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult or minor immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychologist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection.

Specifically, mandated reporters include: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF) and Substance Abuse Treatment Facilities. All other individuals who may witness a reportable event may voluntarily report it.

The timeframes within which critical incidents must be reported:

The timeframes within which critical incidents must be reported: KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days, of receiving the information. Outside of working hours, the reports shall be submitted to DCF on the first working day that the Kansas Department for Children and Families is in operation after the receipt of such information.

AIR is used to report adverse/critical incidents involving individuals receiving services by providers who are licensed by or contracted with KDADS including all HCBS waivers.

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident. MCOs and their providers are all required to submit AIR reports. MCOs are required to follow-up with KDADS on all substantiated ANE reports. All AIR reports are required to be submitted by direct entry into the KDADS web based AIR system.

Reporting entities/individuals may include (but are not limited to):

All KDADS licensed providers
Community Developmental Disability Organization (CDDO)
Aging and Disability Resource Center (ADRC)
Financial Management Services Providers (FMS)
Community Mental Health Center (CMHC)
Psychiatric Residential Treatment Facilities (PRTF)
Substance Abuse Treatment Facilities
Targeted Case Managers (TCM)
Concerned community members (have the ability)

KDADS Program Integrity staff members provide interactive trainings to entities that could potentially report incidents in the AIR System such as assessing entities, HCBS providers and the MCO’s.

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 or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of plan of care/service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual’s service plan. The information provided by the MCOs is consistent with the state’s abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.
The state has formal agreements for sharing information between agencies, MCO and providers. These include cooperative agreements between KDADS and KDHE, KDADS and KDCF, as well as contracts between KDHE and MCOs, the MCOs and providers. Since MCOs and providers are considered mandatory reporters of abuse, neglect and exploitation they are required to follow K.S.A. 39-1433 and K.S.A. 38-2223 and share information.

All adverse incidents, except those required to be reported to the Department of Children and Families (DCF) indicated below in General. III. A. 1., shall be reported no later than 24 hours of becoming aware of the adverse incident by direct entry into the KDADS web based Adverse Incident Reporting (AIR) system.

All reported incidents are assigned a level of severity when assigned to the appropriate MCO. An AIR report is only screened out and not investigated if it is a duplicate report or a report for a non-HCBS waiver participant.

Per KDADS HCBS Adverse Incident Reporting and Management Standard Policy, General III. A.1. All reports regarding abuse, neglect, exploitation, and fiduciary abuse shall be to the Department of Children and Families (DCF) as required by K.S.A. 39-1433, K.S.A. 38-2223.

All adverse incidents, except those required to be reported to the Department of Children and Families (DCF) indicated below in General. III. A. 1., shall be reported no later than 24 hours of becoming aware of the adverse incident by direct entry into the KDADS web based Adverse Incident Reporting (AIR) system.

The KDADS HCBS Adverse Incident Reporting and Management SOP indicates that CPS needs to be reported to first and then an AIR is filed. All incidents are reported into the AIR system even those that are reported to the State through APS. The MCO’s have 30 days to follow up on any quality of care concerns. KDADS will collaborate with Medicaid Fraud as well as enter the data into the AIR system on all reported fraud cases. KDADS collaborates internally with licensing and program managers for all substantiated cases simultaneously with the AIR report being sent to the MCO for follow-up. Program management outreaches to the involved entities for information on the internal remediation plan.

The MCO’s are required to review the following steps and take the appropriate actions to ensure health and welfare of the waiver participant.
1. Back-up Plan
2. Behavior Support Plan
3. Behavioral Health Follow-up
4. Community Resource Referral
5. Complex Case Round
6. Corrective Action Plan
7. DPOA/Guardian Contact
8. Face-to-face visits
9. Increase Participant Engagement
10. Performance Improvement Plan
11. Integrated Person Centered Service Plan Change
12. Policy/Procedure Request
13. Potential Quality of care issue identified
14. Removal of Self-direction to Agency Directed Services
15. Safeguard Planning
16. TCM Contact

The Managed Care Organization has a 30 day window to follow up with any quality of care concerns.
The MCO staff members are required to attend the KDADS PIC training to learn what constitutes an incident that requires reporting, how to submit a report and the subsequent process for investigating the report. See KDADS HCBS Adverse Incident Reporting and Management policy. Community report to MCO for waiver participants in the home to follow up on the concern as deemed necessary.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.
The Kansas Department for Children and Families, Division of Children's Services and Division of Adult Services is responsible for obtaining and overseeing all reports of child and adult abuse and neglect involving participants as well as all non-abuse/neglect critical incidents involving waiver participants. Each quarter, a spreadsheet of the previous quarter’s participants is compared to a list of all children who have been the subject of allegations of abuse and/or neglect by the Operating Agency's Division of Children and Family Services. The list of all waiver participants is then compared to a list of all children who have been part of an investigation to determine if contact with the alleged victim was made timely and whether a investigation finding was made timely.

KDADS oversees the Adverse Incident System as outlined in inter agency cooperative agreement. This information is sent to the KDADS Program Manager of the Waiver in our QRS System. The MCO reports Critical Incidents through the AIRS system. KDADS Program Integrity and Compliance (PICS) team reviews the MCO process, investigation and outcome of the AIR report. PICS makes a determination if the MCO outcome is satisfactory and if not, will assign a corrective action plan and remediation as necessary.

MCO investigations shall be concluded in one of the following three findings:

Finding #1 - Doesn’t meet adverse incident definition – report reviewed by MCO and does not meet the Adverse Incident definitions as defined.
Finding #2 - MCO action required - Report was reviewed and MCO action is required. (Select all that apply)
1. Back-up Plan
2. Behavior Support Plan
3. Behavioral Health Follow-up
4. Community Resource Referral
5. Complex Case Round
6. Corrective Action Plan
7. DPOA/Guardian Contact
8. Face-to-face visits
9. Increase Participant Engagement
10. Performance Improvement Plan
11. Integrated Person Centered Service Plan Change
12. Policy/Procedure Request
13. Potential Quality of care issue identified
14. Removal of Self-direction to Agency Directed Services
15. Safeguard Planning
16. TCM Contact
Finding #3 - No MCO action required – Report was reviewed and no MCO action is required (e.g. death by natural causes, law enforcement/emergency medical involvement where no suspected ANE documented, etc.).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state’s safeguards are followed. The SED waiver does not allow for restraints. Each participant and their family are notified by the MCO during their Person-Centered Planning meeting of their rights and rights to appeal decisions.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

KAR 30-60-48. De-escalation techniques and emergency behavioral interventions. (a) Each center shall adopt and adhere to written policies and procedures that require the following:

(1) Each staff member, volunteer, and contractor shall utilize only de-escalation techniques or emergency behavioral interventions that the staff member, volunteer, or contractor has been appropriately trained in or is professionally qualified to utilize. Each use of these techniques and interventions shall be consistent with the rights of consumers as listed in K.A.R. 30-60-50.

(2) No practice utilized shall be intended to humiliate, frighten, or physically harm a consumer.

(3) No practice that becomes necessary to implement shall continue longer than necessary to resolve the behavior at issue.

(4) Physical restraint or seclusion shall be used as a method of intervention only when all other methods of de-escalation have failed and only when necessary for the protection of that consumer or others.

(5) Each instance of the utilization of a physical restraint or the use of seclusion shall be documented in the consumer's clinical record required by K.A.R. 30-60-46 and reviewed by supervising staff and the center's risk management program required by K.A.R. 30-60-56.

(6) Each instance in which the utilization of a de-escalation technique or emergency behavioral intervention results in serious injury to the consumer shall be reported to the division.

(b) Each center shall ensure that each affiliated provider with which the center has an affiliation agreement adheres to the center's policies and procedures adopted in compliance with subsection (a) of this regulation. (Authorized by K.S.A. 39-1603(d) and (t), 65-4434(f), and 75-3306b; implementing K.S.A. 39-1603, 39-1604(d), 65-4434(f), 75-3304a, and 75-3307b; effective July 7, 2003.)

As noted in KAR 30-60-48 Each instance of the utilization of a physical restraint or the use of seclusion shall be documented in the consumer's clinical record required by K.A.R. 30-60-46 and reviewed by supervising staff and the center's risk management program required by K.A.R. 30-60-56.

Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

If it is determined that there is suspected unauthorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS reviews concerns on an annual basis and as needed depending on how often concerns are reported to KDADS. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

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...

07/05/2023
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:

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**Appendix G: Participant Safeguards**

**Appendix G-2: Safeguards Concerning Restrains 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 State has added 2 sub-assurances under the QIS sub-section of Appendix G to ensure ongoing monitoring and oversight of unauthorized uses of restrictive interventions. The sub-assurances added were developed to be consistent with global reporting measures that the State developed with the assistance of CMS and New Editions through technical assistance to bring quality reporting into the managed care environment in 2014. The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

  The State is utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

  **i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  **ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:
Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

- The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Methods for detecting unauthorized use of restrictive interventions and ensuring that all applicable state requirements are followed.

Data is analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restraint. KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restraints.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.
2. Performance Improvement Analysis Process including:
   a. Performance Improvement Team including the Program Manager, Quality, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.
3. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual’s plan of care (POC). KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint with the service provider to ensure preventative action is taken for the protection of children.

Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, 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 Director of KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.

The frequency of oversight: Continuous and ongoing.

MCOs as well as CMHCs also conduct on-going education through the Person Center Planning Process to educate and assess the participant and guardian’s knowledge, ability, and freedom from the use of restraints. KDADS staff ensure MCOs and CMHCs educate participants about the unauthorized use of restraint throughout service to the participant. If it is determined that there is suspected un-authorized use, the KDADS Licensing Staff instructs the CMHC to report to the appropriate hotline and enter an adverse incident report that will be received by the KDADS PIC team. After receipt of the report, immediate remediation would occur. KDADS staff will be responsible for ensuring these protocols are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.
The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.
KDADS licensing ensures that each CMHC’s critical incident reporting policy and procedures adhere to the State current guidance and are being implemented as written. Licensing staff instruct CMHC to notify the appropriate hotline and enter the adverse incident report via KDADS website. Program Integrity submits all reported uses of medications to the appropriate MCO. MCO must complete the follow up process on all submitted AIR report within 30 days of assignment.

KDADS licensing conducts a full review of each CMHC every two years. In the off years, a compliance review is conducted which includes review of a sample of open and closed cases at each CMHC.

KDADS and the MCO complete separate reviews. Once KDADS licensing completes review, the information is tracked internally. Findings of the review are shared with the CMHC. At the conclusion of the MCO’s review the MCO provides a follow up to the incident. This includes review of authorized/unauthorized use of chemical restraint. The appropriate documentation is outlined in person centered plans, and the measure was the least restrictive for the participant. If additional changes need to occur to any individualized care, the MCO facilitates a meeting with the member and their support circle to identify other strategies to support the member. New strategies are memorialized in the member's plan of care.

Any medication that is used to restrict the movement of a member or is used to manage agitation or aggression of a member in a time of crisis is considered a chemical restraint and needs to be reported through the AIR system to allow appropriate follow-up procedures. KDADS licensure staff reviews all uses of any medication that is used to restrict the freedom of movement or to manage agitation or aggression of the participant. Medications are then reported via Critical Incident Reports to ensure proper usage of medication and proper medical documentation. One the report has been entered through the Adverse Incident Reporting system, KDADS program integrity staff assigns the report to the appropriate MCO to allow form additional follow-up.

KDADS licensing conducts a full review of each CMHC every two years. In the off-years, a compliance review is conducted which includes review of a sample of open and closed cases at each CMHC.

KDADS and the MCO complete separate reviews. Once KDADS licensing completes review, the information is tracked internally. Findings of the review are shared with the CMHC. At the conclusion of the MCO’s review the MCO provides a follow up to the incident. This includes review of authorized/unauthorized use of chemical restraint. The appropriate documentation is outlined in person centered plans, and that the measure was the least restrictive in the for the participant. If additional changes need to occur to any individualized care, the MCO facilitates a meeting with the member and their support circle to identify other strategies to support the member. New strategies are memorialized in the member's plan of care.

Any medication that is used to restrict the movement of a member or is used to manage agitation or aggression of a member in a time of crisis is considered a chemical restraint and needs to be reported through the AIR system to allow appropriate follow-up procedures. KDADS licensure staff reviews all uses of any medication that is used to restrict the freedom of movement or to manage agitation or aggression of the participant is considered a chemical restraint. Medications are then reported via Critical Incident Reports to ensure proper usage of medications and proper medical documentation. Once the report has been entered through the Adverse Incident Reporting system, KDADS program integrity staff assigns the report to the appropriate MCO to allow for additional follow-up.

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.
All medication errors need to be reported to KDADS. A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool 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. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system. Contracted MCOs are charged with the responsibility to oversee and monitor second line medication management. For Schedule I - V medications for children greater than 3 yrs old, the medication must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician. For use in adults 18 yrs of age or older, one of the following criteria must be met:

a. Patient must have a documented diagnosis within the previous 365 days of ADHD, binge eating disorder, hyper somnolence, narcolepsy, depression in accordance with DSM-V or cancer related fatigue, or
b. Prescription must be written by a psychiatrist. Patients with a documented substance abuse diagnosis within the previous 365 days will require
a written peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval, followed by a verbal peer-to-peer, if unable to approve written request.
• Controlled Substances: Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program (PDMP) (aka K-TRACS) MCO's are tasked with following the prior authorization process and run medication adherence reports and outlier reports as well to identify patterns of use/misuse, contraindications and OVER THE MAX limits. Issues revolving incidences of misuse or prescribing are addressed with the individual and or their legal guardian as well as the pharmacy and prescribing physician. Additionally, technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff Member, can filter Member questions and report to a clinical team as necessary.

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 designated quality manager 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.

For community mental health centers, if it is determined that an investigation is warranted (including those events designated in K.A.R. 30-60-55 as requiring investigation), the incident will be referred to a Peer Review Committee who is designated and are deemed to be peer review officers and/or peer review committees duly constituted by the mental health center under peer review and risk management laws, including but not limited to K.S.A. 65-4915 et. seq. and 65-4922 through 4927.

As a result of an investigation, a CMHC may be asked to submit a written corrective action plan. If such program fails to submit a corrective action plan, or 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 12 months from the date of the initial critical incident, the program's license may be revoked. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged medications that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool 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. Medical errors must be reported as critical incidents to the state web-based critical
incident reporting system. KDADS is responsible for oversight of this reporting system.

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 Kansas Department for Aging and Disability Services (KDADS-LTSS) has primary responsibility for overseeing unauthorized, restrictive interventions. KDADS-LTSS works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue. Information and findings are reported to KDHE waiver managers via quarterly and annual reports as well as reported to KDHE through quarterly/annual reports during the Long-Term Care Committee Meeting. Methods for detecting unauthorized use of restrictive interventions and ensuring that all applicable state requirements are followed.

Data is analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restraint. KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restraints.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.
2. Performance Improvement Analysis Process including:
   a. Performance Improvement Team including the Program Manager, Quality, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.
3. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual’s plan of care (POC). KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint with the service provider to ensure preventative action is taken for the protection of children.

Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, 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 Director of KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.

The frequency of oversight: Continuous and ongoing.

MCOs as well as CMHCs also conduct on-going education through the Person Center Planning Process to educate and assess the participant and guardian’s knowledge, ability, and freedom from the use of restraints. KDADS staff ensure MCOs and CMHCs educate participants about the unauthorized use of restraint throughout service to the participant. If it is determined that there is suspected unauthorized use, the KDADS Licensing Staff instructs the CMHC to report to the appropriate hotline and enter an adverse incident report that will be received by the KDADS PIC team. After receipt of the report, immediate remediation would occur. KDADS staff will be responsible for ensuring these protocols are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

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:
All medication errors need to be reported to KDADS. A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool 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. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system.

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 designated quality manager 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.

For community mental health centers, if it is determined that an investigation is warranted (including those events designated in K.A.R. 30-60-55 as requiring investigation), the incident will be referred to a Peer Review Committee who is designated and are deemed to be peer review officers and/or peer review committees duly constituted by the mental health center under peer review and risk management laws, including but not limited to K.S.A. 65-4915 et. seq. and 65-4922 through 4927.

As a result of an investigation, a CMHC may be asked to submit a written corrective action plan. If such program fails to submit a corrective action plan, or 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 12 months from the date of the initial critical incident, the program's license may be revoked. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool 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. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system.

(b) Specify the types of medication errors that providers are required to record:

K.A.R. 28-4-818 (5) states the date and time that each medication is self-administered shall be recorded on the child's medication record. Any noted adverse reactions shall be documented. Each licensee shall review the record for accuracy and shall check the medication remaining in the container against the expected remaining doses.

According to the AIR system medication errors include: Misuse of Medications - The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.

(c) Specify the types of medication errors that providers must report to the state:
Providers are responsible for reporting to the State any medication errors that are determined by contracted health professionals to have an adverse effect including, but not limited to, hospitalization or calls to poison control.

- 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.
All Medicaid providers, including all SED waiver providers, must immediately report all critical incidents to the State. KDADS is the state agency responsible for the on-going monitoring. Medication administration errors that result in a need for medical services are reportable critical incidents. State staff will analyze data from critical incident reporting to identify trends in medication administration errors. Providers with possible trends in medication administration errors will be required to submit a corrective action plan to the State. A critical incident report, including any possible trends, will be provided to the State Medicaid Agency via the KDHE waiver managers on quarterly basis.

Contracted MCOs are charged with the responsibility to oversee and monitor second line medication management. For Schedule I - V medications for children greater than 3 yrs old, the medication must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician. For use in adults 18 yrs of age or older, one of the following criteria must be met:

a. Patient must have a documented diagnosis within the previous 365 days of ADHD, binge eating disorder, hyper somnolence, narcolepsy, depression in accordance with DSM-V or cancer related fatigue or

b. Prescription must be written by a psychiatrist. Patients with a documented substance abuse diagnosis within the previous 365 days will require a written peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval, followed by a verbal peer-to-peer, if unable to approve written request.

• Controlled Substances: Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program (PDMP) (aka K-TRACS) MCO’s are tasked with following the prior authorization process and run medication adherence reports and outlier reports as well to identify patterns of use/misuse, contraindications and OVER THE MAX limits. Issues revolving incidences of misuse or prescribing are addressed with the individual and/or their legal guardian as well as the pharmacy and prescribing physician. Additionally, technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff Member, can filter Member questions and report to a clinical team as necessary.

The Department of Children and Family oversight responsibility:
An onsite survey inspection shall be completed by the licensing division prior to issuance of a license and annually thereafter to ensure the applicant/permittee/licensee is in compliance with the laws and regulations. Onsite inspections shall occur during a regulatory complaint investigation and compliance surveys as needed, to verify compliance.

1. Onsite inspection of the facility is completed within policy timelines.
   a. Timelines for completion of Initial Licensing Inspections by program type
      i. Initial licensing survey Family Foster Home and Family Foster Home Military Base Approval
         1. Onsite inspection shall be completed within 15 calendar days of assignment
         2. Extension to exceed 15 days may be granted by the regional supervisor
         3. Document of the extension shall be documented in the electronic licensing system facility narrative
      ii. Initial licensing survey Family Foster Home Non-Related Kinship, Family Foster Home Relative Approval
          1. Onsite inspection shall be completed within 30 calendar days of assignment
          2. Extension to exceed 30 days may be granted by the regional supervisor
          3. Document of the extension shall be documented in the electronic licensing system facility narrative
      iii. Initial licensing survey Adoption Placement Agency, Attendant Care Center, Child Placement Agency, Detention Center, Foster Care Placement Agency, Group Boarding Home, Residential Center, Secure Care Center, Staff Secure Facility
          1. Onsite inspection shall be completed within 30 calendar days of assignment
          2. Extension to exceed 30 days may be granted by the regional supervisor
          3. Document of the extension shall be documented in the electronic licensing system facility narrative
   b. Timelines for completion of Annual Renewal Inspections by program type
      i. Annual renew of Family Foster Home and Family Foster Home Military Base Approval, Family Foster Home Non-Related Kinship, Family Foster Home Relative Approval, Adoption Placement Agency, Attendant Care Center, Child Placement Agency, Detention Center, Foster Care Placement Agency, Group Boarding Home, Residential Center, Secure Care Center, Staff Secure Facility
         1. Onsite inspection shall be completed within 30 calendar days of assignment
         2. Extension to exceed 30 days may be granted by the regional supervisor
3. Document of the extension shall be documented in the electronic licensing system facility narrative.
2. Onsite inspection results are completed in the electronic licensing system at the time of the inspection
   a. The applicable survey template is applied in the electronic licensing system.
   b. The summary and recommendations. Section I is completed at the time of the onsite visit
   c. A notice of survey findings is completed and provided to the licensee and sponsoring child placement agency, if applicable, following the onsite inspection.
   d. Licensee was found to be in full compliance with the regulatory requirements
      i. Survey summary section II is completed, noting full compliance, in the electronic licensing system
      ii. Survey completion date is entered and workflow is closed
      iii. Electronic licensing system notifies the assigned administrative assistant survey is completed
      iv. Administrative assistant completes a review of the electronic background checks within 2 business days of survey completion
1. All required background checks are returned and on file
   a. Administrative assistant issues the license
   b. Administrative assistant provides a copy of the license to the licensee and sponsoring child placement agency if applicable.
2. Required background checks are not on file
   a. Administrative assistant sets a facility reminder alert in the electronic licensing system to check for results
   b. Administrative assistant completes a follow up check within 7 business days
   c. All required background checks are returned and on file
   d. Administrative assistant issues the license
   e. Administrative assistant provides a copy of the license to the licensee and sponsoring child placement agency if applicable.
   e. Licensee was found to be in non-compliance with the regulatory requirements, licensee is notified via notice of survey findings corrections are due within 5 calendar days
      i. Survey Summary section II is completed in the electronic licensing system, noting areas of non-compliance identified
      ii. Survey remains open for 5 calendar days
      iii. A compliance action plan is received addressing areas of non-compliance within 5 days
1. Surveyor reviews the compliance action plan submitted verifying plan addresses violations cited.
2. Surveyor accepts or denies the compliance action plan
   a. If accepted surveyor accepts compliance action plan, images compliance action plan and returns accepted copy to the licensee or CPA as appropriate and proceeds to step 3
   b. If denied, surveyor returns Compliance Action Plan for corrections to the licensee or CPA as appropriate
3. All areas of non-compliance have been corrected and compliance action plan is completed
   a. Surveyor completes Survey Summary and Recommendations Section III Corrections Received. No on-site compliance check is necessary. Licensure recommended
   b. Survey completion date is entered and workflow closed
   c. Electronic Licensing System notifies administrative assistant survey is completed and administrative assistant completes step d iv 1 and 2.
4. Areas of non-compliance are not corrected and compliance action plan target date exceeds 5 days.
   a. Surveyor completes Survey Summary and Recommendations Section III Recommend ongoing compliance checks.
      i. Survey completion date is entered and workflow closed
      b. Surveyor will assign a compliance survey due the date of Completion on the Compliance Action Plan.
      i. If the Compliance Action Plan was not completed by the target date, the licensee or sponsoring agency may submit an FCL Supplemental Form addressing the delayed completion, identify the continued regulatory non-compliance and establish a new completion date.
      ii. The supplemental form shall be reviewed by the surveyor and either accepted or denied.
      iii. The accepted or denied supplemental form shall be returned to the licensee or sponsoring agency and shall image the FCL Supplemental Form in facility images.
      iv. If the supplemental plan is accepted, the compliance survey due date shall be updated to reflect the Compliance Action Plan due date.
      v. If the FCL Supplemental Plan is denied, the compliance survey will be completed in accordance with step c.  
      c. Surveyor completes the compliance survey by completing Survey Summary Sections I and II.
   i. The compliance survey may be completed by receiving corrections via emailed documents or pictures, or on-site confirmation. All received corrections, excluding protected health documents, fingerprints or other criminal
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.


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 instances of 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 non-preventable causes

\[
N = \text{Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes}
\]
\[
D = \text{Number of unexpected deaths}
\]

Data Source (Select one):

Other

If 'Other' is selected, specify:

record reviews

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Responsible Party for 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

Frequency of data aggregation and analysis (check each that applies):

- Continuously and Ongoing

Other
Specify:

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures

Data Source (Select one):
Other
If 'Other' is selected, specify:
record reviews

Responsible Party for data collection/generation (check each that applies):

- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other

Frequency of data collection/generation (check each that applies):

- Weekly
- Monthly
- Quarterly
- Annually

Sampling Approach (check each that applies):

- 100% Review
- Less than 100% Review
- Representative Sample
Confidence Interval =

Describe Group:
KanCare Managed Care Organizations; Community Mental Health Centers
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### Performance Measure:

Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation

- **Numerator:** Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
- **Denominator:** Number of waiver participants interviewed by QMS staff or whose records are reviewed

### Data Source (Select one):
- Record reviews, off-site

If ‘Other’ is selected, specify:
### Responsible Party for data collection/generation

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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

\[ N = \text{Number of participants' reported critical incidents that were initiated and reviewed within required time frames} \]
\[ D = \text{Number of participants' reported critical incidents} \]

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
critical incident management system

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Confidence Interval = [Blank]

| × Other Specify: KanCare Managed Care Organizations; Community Mental Health Centers | Annually | Stratified Describe Group: [Blank] |
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| Other Specify: [Blank] |

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Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures

\[ N = \text{Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver} \]
\[ D = \text{Number of reported critical incidents} \]

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): |
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| | | Confidence Interval = |
× Other Specify: KanCare MCOs; Community Mental Health Centers | Annually | Stratified Describe Group: |
× Continuously and Ongoing | Other Specify: |
Other Specify: | | |
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<tr>
<td>Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency</td>
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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
Numerator: Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
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<td>Sub-State Entity</td>
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Performance Measure:
Number and percent of unauthorized uses of restrictive interventions that were appropriately reported
Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported
Denominator: Number of unauthorized uses of restrictive interventions

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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**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 Numerator: Number of HCBS participants who received physical exams in accordance with State policies Denominator: Number of HCBS participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
If ‘Other’ is selected, specify:

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Confidence Interval =  
95/5 |
| Other  
Specify: | Annually | × Stratified  
Describe Group:  
proportioned by MCO |
| × Continuously and Ongoing | | Other  
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| Other  
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Performance Measure:
Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan

Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
Denominator: Number of waiver participants with a red flag designation

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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**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-LTSS 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. KDADS utilizes the Adverse Incident Reporting System (AIR) to track all adverse/critical incidents.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

### ii. Remediation Data Aggregation

#### Remediation-related Data Aggregation and Analysis (including trend identification)

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<tr>
<td>KanCare Managed Care Organizations; Community Mental Health Centers</td>
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| Other Specify:                              |                                                                 |

#### c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ☐ No
- ☑ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the state’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements
i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of 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.

The sample for the quarterly desk review is based off of waiver standards and is statistically significant. As part of one of the performance measures in this waiver, a survey is mailed to each individual on the quarterly sample. The survey includes questions regarding current services and the individuals/guardians experience with HCBS services and the waiver. Results of this survey, if returned to the State, are logged into our Quality Review Tracking system and made available to HCBS KDADS staff. If there are concerns relayed in the returned survey, HCBS Quality Management Staff, will send an alert to the Program Manager. This alert contains information documented on the survey, so the Program Manger can follow up accordingly.

KDADS has a continual quality review process for the HCBS Performance Measures. This cycle is completed on a quarterly basis, giving continuous feedback to appropriate staff and stakeholders. The KDADS HCBS Quality Management Staff are responsible for desk reviews, for the various Performance Measures located in the waiver. Participants are selected for review based off of a statistically significant sample, pulled by KDADS, according to standards in the waiver.

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Level of Care assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. A representative sample of HCBS Waiver individual’s case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS Financial and Information Services Commission (FISC), and assigned to the appropriate KDADS Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a “non-review” and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a “non-review.”

FISC will generate and provide a report regarding findings to the KDADS Program Manager to review and to remediate as necessary.

KDADS Program Evaluation staff collect data, aggregate it, analyze it and provide information regarding discrepancies and trends to Program staff, Quality Review staff, KDHE staff, MCOs 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:
- assign remediation plans and/or Quality Improvement Plan(s)
- re-education of best practices
- training of the QR staff to ensure the protocols are utilized correctly
- protocol revisions to capture the appropriate data
- policy clarifications to MCOs to ensure adherence to policy
- Meet with MCO LTSS Directors
- Interagency collaboration with KDHE and DCF.

KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports. KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports.

ii. System Improvement Activities
Responsible Party (check each that applies):

- [x] State Medicaid Agency
- [x] Operating Agency
- Sub-State Entity
- [x] Quality Improvement Committee
- [x] Other
  Specify:
  KanCare Managed Care Organizations (MCOs)

Frequency of Monitoring and Analysis (check each that applies):

- Weekly
- Monthly
- Quarterly
- Annually

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.

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Level of Care assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. A representative sample of HCBS Waiver individual’s case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS Financial and Information Services Commission (FISC), and assigned to the appropriate KDADS Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a “non-review” and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a “non-review.”

FISC will generate and provide a report regarding findings to the KDADS Program Manager to review and to remediate as necessary.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Data analysis is completed and remediated for any assurance or sub-assurance less than 87%. KDADS Quality and Program Coordinator will notify the provider of areas below 87% with details of each finding. The provider will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by the KDADS HCBS Director for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, the KDADS Quality and Program Coordinator will continue to monitor through Quality Reviews to ensure compliance and recommend system improvements and/or next steps as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (Select one):
b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey:
- NCI Survey:
- NCI AD Survey:
- Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas’ statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit.

Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The MCOs make payments 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 1915(b) waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - 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 but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken:
e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
1. Oversight of the program integrity functions 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 of clean claims that are paid by the managed care organization within the timeframes specified in the contract

\[
N = \text{Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract}
\]

\[
D = \text{Total number of provider claims}
\]

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSS/DAI encounter data

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- **Other** Specify:
  - KanCare Managed Care Organizations (MCOs)
  - Other Specify:
    - Continuously and Ongoing

**Data Aggregation and Analysis:**

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<th>Frequency of data aggregation and analysis (check each that applies):</th>
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<td>KanCare MCOs participate in analysis of this measure’s results as determined by the State Operating Agency</td>
<td>Continuously and Ongoing</td>
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### 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

\[
N = \text{number of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS}
\]

\[
D = \text{Total number of capitation (payment) rates}
\]

**Data Source (Select one):**

- Other

If 'Other' is selected, specify:

**Rate Setting Documentation**

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<tr>
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**ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.**

The State established an interagency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the interagency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.

The MCOs are responsible for monitoring for ensuring that service plans are rendered appropriately as well as responsible for the payment to the provider.
Methods for Remediation/Fixing Individual Problems

Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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<td>Specify: KanCare MCOs</td>
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iii. 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
- [x] Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)
a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The capitated rates are developed by a State Contracted Actuary. The resulting rates are certified to and approved by CMS.

Under managed care, HCBS provider rates are determined through contracting with the MCO while the state sets actuarial sound capitation rates that are paid to the MCO for each waiver beneficiary. The state sets the floor for the minimum rates that are required to be paid by the MCO, however. For the SED Waiver, the State’s floor rates are based on prior fee for service rates and are available through KMAP. Capitation rates are based on actuarial analysis of historical data for all SED program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The State’s Contracted Actuary does not set provider floor rates.

All waiver services are included in the capitation rates.

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 delivering SED waiver services. All claims are either submitted through the MMIS portal, the State’s front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. 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.

Post payment billings are conducted by the MCOs.

The State’s Quality Management Staff (QMS) conducts quarterly and annual reviews, which includes reviewing case file documentation to see if choice was provided and if the participant signed the Choice document. Additionally, participant interviews have been completed, inquiring if they were provided choice. During the interview of the participant QMS identifies if a provider choice form was presented to the family, asks how the provider choice was decided and if services were rendered according to those identified on the participant’s Service Plan.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

- Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state’s contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs. The MCOs reimburse on claims provided. Providers are paid by the MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

○ No. The state does not make supplemental or enhanced payments for waiver services.
Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

○ No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

○ Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

○ The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

○ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

○ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:
Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used.
Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

   Appropriation of State Tax Revenues to the State Medicaid agency
   ✗ Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:
The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State’s fiscal agent through the Medicaid Management Information System using the InterChange 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:
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
  - 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:

Per Appendix I-2-a., Capitation rates are based on actuarial analysis of historical data for all SED 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.

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: Hospital

<table>
<thead>
<tr>
<th>Col. 1</th>
<th>Col. 2</th>
<th>Col. 3</th>
<th>Col. 4</th>
<th>Col. 5</th>
<th>Col. 6</th>
<th>Col. 7</th>
<th>Col. 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Factor D</td>
<td>Factor D'</td>
<td>Total: D+D'</td>
<td>Factor G</td>
<td>Factor G'</td>
<td>Total: G+G'</td>
<td>Difference (Col 7 less Column4)</td>
</tr>
<tr>
<td>1</td>
<td>1699.00</td>
<td>13500.00</td>
<td>15199.00</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
<td>26801.00</td>
</tr>
<tr>
<td>2</td>
<td>1714.07</td>
<td>13500.00</td>
<td>15214.07</td>
<td>33458.67</td>
<td>8541.33</td>
<td>42000.00</td>
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</tr>
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<td>15226.30</td>
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<td>42000.00</td>
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<td>8541.33</td>
<td>42000.00</td>
<td>26758.81</td>
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<tr>
<td>5</td>
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<td>8541.33</td>
<td>42000.00</td>
<td>26747.00</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level of Care:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td>Year 1</td>
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<td>Year 2</td>
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<td>4900</td>
<td>4900</td>
</tr>
<tr>
<td>Year 5</td>
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<td>4900</td>
</tr>
</tbody>
</table>

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 estimate is derived from the unduplicated participants and the total days of actual waiver coverage from the CMS-372 reports for Waiver Years 1-3 prior to the COVID pandemic (04/01/2017-03/31/2020). Based on that analysis, the state used an estimated average of 245 for the upcoming Waiver period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:
Factor D was estimated by utilizing Managed Care encounter data from the Kansas Medicaid Information System and analyzing trends of annual utilization from April 2017 through March 2021. This will only be a projection of MCO encounters and not be reflective of the State’s Capitation payments made to the MCO.

Service level assumptions include the following. The State assumed overall utilization would align with pre-COVID pandemic levels. The SED Waiver did experience overall decreases in participation and utilization during the COVID pandemic. Specifically, the State assumed Wraparound Facilitation, Short-Term Respite and Attendant care would all resume pre-COVID levels of utilization throughout the 5 years of the renewal periods.

For Attendant Care services: in light of the prolonged periods of isolation and increased mental health challenges resulting from the pandemic, the State anticipates a continued growth in the utilization of this service. The State also based estimates on the growing need for support services due to the increase in anxiety and depression rates nationwide that impact our community mental health centers that serve the SED waiver children. Attendant Care services offer essential one-on-one mental health support to address the specific needs of individuals affected in their homes and communities.

For Parent Support and Training services, the State assumed a 10% increase in participation and a slight increase in utilization per participant over the course of the 5-year period. This estimated increase is primarily related to the change in allowing tele video options for training.

For Professional Resource Family Care, the State assumed a participation level that was an average of the 3-year period prior to the pandemic.

For Independent Living/Skills Building, the State assumed an approximate 10% annual increase in participants of this service over the waiver period. This assumption is based on the change in the Waiver that will change the minimum age for this service from 17 to 14 years. The State estimates that 20% of the expanded age group will utilize this service and the end of the waiver period.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D’ was projected by subtracting the Factor D cost estimates from the estimated MCO encounter payments that will be made to the State’s Managed Care Organizations over the period of the Waiver.

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:
In Kansas, Factor G represents hospitalization costs for KanCare beneficiaries receiving services through an Inpatient Psychiatric facility for individuals aged 21 and younger.

These costs are paid by the state through managed care capitated payments which cover all Medicaid costs. The average all-inclusive capitated costs for these beneficiaries while admitted to the institutional setting averaged approximately $1,700 annually prior to the COVID pandemic which was derived on data from the State’s Medicaid data system. Given the length of stay difference between the Waiver and the institutional stay, the State extrapolated the institutional capitated cost based on the Waiver length of stay to determine an historical Factor G cost of approximately $35,000.

Based on the actual state expended capitated rate payment data, the state projects costs of $42,000 annually in the new Waiver period assuming a 20% cost growth along with similar lengths of stay experienced prior to the COVID-19 pandemic. The state assumed cost growth is directly related to the state’s current processes in expansion of the provider network for these inpatient services.

In order to breakout the total capitated cost of $42,000 between Factor G and G’, the state analyzed MCO encounter claims for Waiver Years 1-3 (04/01/2017-03/31/2020) to proportionally split the cost between hospital and other state plan share of cost. This resulted in a Factor G of $33,458 and a Factor G’ of $8,541.

At this point, the state does not currently project substantial increases in utilization or costs during the 5-year Waiver period.

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:

In Kansas, Factor G’ represents non-hospitalization costs for KanCare beneficiaries receiving services through an Inpatient Psychiatric facility for individuals aged 21 and younger.

These costs are paid by the state through managed care capitated payments which cover all Medicaid costs. The average all-inclusive capitated costs for these beneficiaries while admitted to the institutional setting averaged approximately $1,700 annually prior to the COVID pandemic which was derived on data from the State’s Medicaid data system. Given the length of stay difference between the Waiver and the institutional stay, the State extrapolated the institutional capitated cost based on the Waiver length of stay to determine an historical Factor G cost of approximately $35,000.

Based on the actual state expended capitated rate payment data, the state projects costs of $42,000 annually in the new Waiver period assuming a 20% cost growth along with similar lengths of stay experienced prior to the COVID-19 pandemic. The state assumed cost growth is directly related to the state’s current processes in expansion of the provider network for these inpatient services.

In order to breakout the total capitated cost of $42,000 between Factor G and G’, the state analyzed MCO encounter claims for Waiver Years 1-3 (04/01/2017-03/31/2020) to proportionally split the cost between hospital and other state plan share of cost. This resulted in a Factor G of $33,458 and a Factor G’ of $8,541.

At this point, the state does not currently project substantial increases in utilization or costs during the 5-year Waiver period.

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.
## 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.

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendant Care Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendant Care</td>
<td>x</td>
<td>15 minutes</td>
<td>2000</td>
<td>75.00</td>
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<td>978000.00</td>
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</tr>
<tr>
<td>Independent Living/Skills Building Total:</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Independent Living/Skills Building</td>
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<td>450</td>
<td>6.00</td>
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<td>117423.00</td>
<td></td>
</tr>
<tr>
<td>Short-Term Respite Care Total:</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term Respite Care</td>
<td>x</td>
<td>15 minutes</td>
<td>1500</td>
<td>425.00</td>
<td>6.52</td>
<td>4156500.00</td>
<td></td>
</tr>
<tr>
<td>Parent Support and Training Total:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
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<td>15 minutes</td>
<td>3000</td>
<td>25.00</td>
<td>10.87</td>
<td>815250.00</td>
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<tr>
<td>Group</td>
<td>x</td>
<td>15 minutes</td>
<td>200</td>
<td>25.00</td>
<td>3.26</td>
<td>16300.00</td>
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<td>Professional Resource Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Grand Total:**

| Total: Services included in capitation: | 8125991.00 |
| Total: Services not included in capitation: | 8325991.00 |
| Total Estimated Unduplicated Participants: | 4900 |
| Factor D (Divide total by number of participants): | 1609.00 |

Average Length of Stay on the Waiver: 245
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Resource Family Care</td>
<td>×</td>
<td>1 day</td>
<td>25</td>
<td>18.00</td>
<td>150.04</td>
<td>67518.00</td>
<td></td>
</tr>
<tr>
<td>Wraparound Facilitation Total:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2175000.00</td>
</tr>
<tr>
<td>Wraparound Facilitation</td>
<td>×</td>
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<td>4000</td>
<td>25.00</td>
<td>21.75</td>
<td>2175000.00</td>
<td></td>
</tr>
</tbody>
</table>

**Total Estimated Unduplicated Participants:** 4900

**Factor D (Divide total by number of participants):**

- Services included in capitation: 1699.00
- Services not included in capitation: 1714.07
- Average Length of Stay on the Waiver: 245

---

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 9)**

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Attendant Care Total:</td>
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<td>1 hour</td>
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<td>43.49</td>
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<td></td>
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<td>4156500.00</td>
</tr>
</tbody>
</table>

**GRAND TOTAL:** 839846.75

- Total: Services included in capitation: 839846.75
- Total: Services not included in capitation: 1714.07
- Average Length of Stay on the Waiver: 245
### Waiver Component Capitation

<table>
<thead>
<tr>
<th>Service/Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Respite Care</td>
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<td>425.00</td>
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<td>415650.00</td>
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<tr>
<td>Parent Support and Training Total:</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Individual</td>
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<td>3075</td>
<td>25.00</td>
<td>10.87</td>
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<td>205</td>
<td>25.00</td>
<td>3.26</td>
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<tr>
<td>Professional Resource Family Care</td>
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</tr>
<tr>
<td>Professional Resource Family Care</td>
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<td>25</td>
<td>18.00</td>
<td>150.04</td>
<td>67518.00</td>
<td></td>
</tr>
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<tr>
<td>Wraparound Facilitation</td>
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<td>4000</td>
<td>25.00</td>
<td>21.75</td>
<td>2175000.00</td>
<td></td>
</tr>
</tbody>
</table>

**GRAND TOTAL:**

- Services included in capitation: 8398946.75
- Services not included in capitation: 4900
- Total Estimated Unduplicated Participants: 4900
- Factor D (Divide total by number of participants): 1714.07

### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

- ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**
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<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1043200.00</td>
</tr>
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<td>2000</td>
<td>80.00</td>
<td>6.52</td>
<td>1043200.00</td>
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<td></td>
<td></td>
<td></td>
<td>143517.00</td>
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<td></td>
<td></td>
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<tr>
<td>Short-Term Respite Care</td>
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<td>1500</td>
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</table>

GRAND TOTAL: 8458862.50
Total: Services included in capitation: 8458862.50
Total: Services not included in capitation: 4000
Total Estimated Unduplicated Participants: 4900
Factor D (Divide total by number of participants): 1726.30
Services included in capitation: 1726.30
Services not included in capitation: 1726.30
Average Length of Stay on the Waiver: 245

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.
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<thead>
<tr>
<th>Waiver Service Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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</tr>
<tr>
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<td>1500</td>
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<tr>
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<td>1 day</td>
<td>25</td>
<td>18.00</td>
<td>150.04</td>
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Total: Services included in capitation: 8533818.25
Total: Services not included in capitation: 8533818.25
Total Estimated Unduplicated Participants: 4900
Factor D (Divide total by number of participants): 1744.19

Average Length of Stay on the Waiver: 245

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that...
service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

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<th>Waiver Service/Component</th>
<th>Capitation</th>
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<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
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<tbody>
<tr>
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<tr>
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<td>15 minutes</td>
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<tr>
<td>Professional Resource Family Care</td>
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<td>1 day</td>
<td>25</td>
<td>18.00</td>
<td>150.04</td>
<td>67518.00</td>
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</tr>
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<td>×</td>
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<td>4000</td>
<td>25.00</td>
<td>21.75</td>
<td>2175000.00</td>
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</table>

**GRAND TOTAL:**

- Total: Services included in capitation: 8391734.00
- Total: Services not included in capitation: 67518.00
- Total Estimated Unduplicated Participants: 4900
- Factor D (Divide total by number of participants): 1753.00
- Services included in capitation: 1753.00
- Services not included in capitation: 67518.00
- Average Length of Stay on the Waiver: 245