

## Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:  
Individual Plan of Care (POC)

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

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### 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:*

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

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

When an individual with a physical disability is determined eligible for services in a Nursing Facility, a PD Targeted Case Manager (TCM) provides certain information and support to the consumer regarding available services and the plan development process. The TCM: (1) provides information to the consumer and/or his/her legal representative regarding alternate service options available through the PD waiver, and (2) offers the choice of either institutional care or home and community based services (HCBS). The consumer indicates on the Consumer Choice form, provided by the TCM, his/her choice of institutional care or HCBS. Through the use of this document, and a list of rights and responsibilities, the consumer is counseled regarding his/her participation in the service plan design and informed of the self-direct option.

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

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

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

- a. All applicants for PD waiver services must undergo an assessment to determine functional eligibility for the waiver. The first two (2) pages of the PD Uniform Assessment Instrument (UAI) are used for this assessment. This is the same instrument utilized for nursing facility eligibility (K.S.A. 39-7,100) and for assessing deinstitutionalized individuals.

The state's ADRC contractor conducts the assessment of the applicant within five (5) working days of the referral, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. The participant-centered service plan, or Plan of Care (POC) is developed as soon as possible after the applicant for PD waiver services is determined eligible for services and indicates his/her choice to receive home and community based services. The POC is developed by the consumer with assistance from the consumer's chosen KanCare MCO. Family members and other representatives can participate in the process if the consumer so chooses.

- b. The primary source of information gathered about the consumer is the consumer himself/herself. If needed, with the consumer's signed release of information, the MCO may contact other information sources such as physicians, other health care providers, and/or family members. A formal assessment of needs, abilities, and health status is conducted using the PD Uniform Assessment Instrument (UAI). The consumer is assessed and the POC is written utilizing the consumer's "typical day" criteria.

- c. Consumers are informed of services available through the waiver program by the ADRC during the initial assessment and eligibility determination process. This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the consumer's needs.

- d. The plan development process ensures that the service plan addresses the consumer's needs, goals, and preferences by using consumer-specific information from both the assessment and direct input from the consumer

and any significant others to guide the process. The plan development process is further ensured by the direct involvement of, and monitoring by, the consumer and/or legal representative, and any persons identified by the consumer to be involved in the plan development process. Person-centeredness of the plan is reinforced through regulation which requires consumer participation in, and approval of, the plan (K.A.R. 30-5-309). The consumer has the right to make changes to the plan deemed necessary. Changes to the plan can be made at any time to reflect changes in the consumer's needs, with reassessment conducted at least on an annual basis. Upon authorization of the plan, and when changes in status occur, the MCO is required to notify the consumer, the legal representative, if appropriate, all service providers, and the consumer's FMS provider of the authorization by use of a Notice of Action (NOA) form accompanied by the consumer's POC. Thus, all involved parties are informed and serve to monitor and advocate for the needs and wishes of the consumer. If at any time, an action is taken related to the service plan that does not meet the satisfaction of the consumer, the consumer may utilize the MCO's grievance process or the state fair hearing process that would ultimately ensure the consumer's needs are being met.

e. Waiver and other services are coordinated by the MCO's care management staff who utilizes knowledge of available services, both formal and informal in the consumer's community, as well as information from the consumer regarding his/her current utilization of those services as well as other available services including Medicaid health services. Currently utilized services and available community services are taken into consideration as the consumer and the MCO design the Plan of Care.

f. The Plan of Care identifies the entities responsible to provide the services selected by the consumer. In addition, once the consumer's service plan has been developed, the Attendant Care Worksheet is created by the MCO, which defines daily living tasks applicable to the functional needs identified in the consumer's Uniform Assessment Instrument. These daily living tasks correspond with the service plan and are the responsibility of the Personal Care Attendant. Monitoring of the plan by the consumer is discussed with the consumer by the MCO, and such monitoring is also the responsibility of the MCO and is conducted in an ongoing manner as the MCO visits with the consumer regularly, and confers with providers as needed to ensure that appropriate and sufficient services are being provided to meet the needs, goals, and preferences of the consumer. The Quality Assurance/Performance Improvement system established by the State also monitors the quality of services, and helps assure the health and safety of the consumer, to the extent possible.

g. The service plan/Plan of Care is changed and updated at least annually in conjunction with a required reassessment using the PD Uniform Assessment Instrument (UAI) or as is necessary when the consumer's needs have increased, decreased, or changed in any way. An increase in hours must be justified by a change in the consumer's health and safety needs, medical condition, or informal supports.

Safeguards related to mitigating conflict of interest in the development of service plans:

Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for plan of care development, and will be using their internal staff to provide that service. Kansas requires that conflict of interest be mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers the plan of care development, and making that an MCO function. (In addition, conflict has been mitigated by Kansas separating the level of care determination from any service delivery or plan of care development.) Some of the additional safeguards that will be in place to ensure that there is no conflict of interest in this function include the following operational strategies for each MCO:

For Amerigroup:

- Care managers (CM) and Service Coordinators (SC) do not have access to financial data such as the rates the providers are paid
- CM and SCs cannot adjudicate or adjust claims
- Policies and procedures focus on POCs being member centric and providing choice among network providers
- Members get copies of the POC that provide the member the opportunity to identify mistakes and/or complain about CM/SC interaction
- Long-Term Services and Supports (LTSS) Members sign their assessment on IPAD
- Quality department monitors and trends complaints including those related to SCs
- Health Plan conducts CAHPS surveys that include opportunities for members to express their satisfaction with CM/SC
- Health Plan selects a sample of members per month, including those participating in LTSS, to send EOBs for services billed to conduct fraud surveillance and to drive complaints to the MCO as applicable if they are dissatisfied with their services
- MCO LTSS managers audits SC/CM to assure member driven service plans
- Members can appeal decisions related to a reduction of HCBS and any other services

- MCO will submit a report to the state, on a for information basis, of members for whom any reduction in the service plan was made and excluding services that are reduced to conform with benefit or program limits, because a consumer transitions out of a particular program HCBS program, loses eligibility, or other similar circumstance.
- MCO will allow existing POC to remain in place for 180 days or until the member is re-assessed, whichever comes first. Any reduction of a waiver service during that 180 day period must be reviewed and approved by the state.

#### For United Healthcare:

All operations, including but not limited to the clinical operations and functions of every UnitedHealthcare Community Plan are designed to ensure no conflict of interest with the Teams that are responsible for Plans of Care, service authorization, monitoring, payment and business management of the Health Plan. To this end, standard within the Kansas UnitedHealthcare Community Plan the following safeguards exist:

- The State of KS (not UnitedHealthcare Community Plan) retains the responsibility for member initial and annual eligibility determinations for waiver programs.
- UnitedHealthcare Community Plan has developed a network of contracted HCBS providers to deliver waiver services & does not directly employ any HCBS providers (including Financial Management Services providers for members who choose Consumer-Directed care).
- A member transitioning to UnitedHealthcare Community Plan effective January 1, 2013 will continue to receive services for up to 180 days according to the existing plan until a new assessment is completed by health plan care coordinators. Any potential reductions in waiver services will be reviewed/approved by the state.
- Service plans are developed based on member clinical and functional assessment (state approved), analysis of available informal supports, and standardized internal task/hour guidelines. Inter-rater reliability activities including joint member visits are conducted regularly by managers to assure consistency & accuracy of the assessment & service plan development process.
- HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule.
- Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. A utilization management team separate from the care coordination team completes final reviews of the authorization to assure that the member is eligible for the requested waiver service and that the documentation supports the proposed service plan. Inter-rater reliability activities are also conducted regularly with the utilization management team.
- The Team that conducts care coordination and Plan of Care development is different from the Team that authorizes care and they have different reporting structures.
- All UnitedHealthcare health plans including the Kansas UnitedHealthcare Community Plan offer no compensation for any clinical staff that creates incentives for activities that would deny, limit, or discontinue medically necessary services to any member. Plan of Care development and service authorization decisions are based on appropriateness of care and existence of coverage.

#### For Centene/Sunflower: Conflict of Interest Safeguards

##### Safeguards

Sunflower State Health Plan's operations, including but not limited to the clinical operations and functions, are designed to ensure no conflict of interest exist between the teams that are responsible for Service Plans or Plan of Care, service authorization, monitoring, payment and business management of the Health Plan.

##### HCBS Providers Independence & Member Choice

Sunflower State Health Plan has developed a network of contracted HCBS providers to deliver waiver services and does not directly employ any HCBS providers (including Financial Management Services (FMS) providers for members who choose Consumer-Directed care).

Sunflower State works with the members to ensure member choice from our contracted network of providers. HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule. The Case Manager will work closely with the member and our provider network to meet the member's service plan or plan of care.

A member transitioning to Sunflower State Health Plan effective January 1, 2013 will continue to receive services for up to 90 days according to the existing plan until a new assessment is completed by health plan care coordinators. Please note that the State of Kansas retains responsibility for members' initial and annual eligibility

determinations for waiver programs.

#### Service Plans

Service Plans are developed based on member clinical and functional assessment tools utilized/mirroring states, analysis of support system/community, utilization of members ADLs and IADL measurement, and leveling of care to determine and standardize tasking/hour guidelines for members' Service Plans. Case Management Managers and Director for Waiver programs, will conduct Case Management inter rater reliability ensuring consistency of case management's assessment and Service Plan development. This will be ongoing, reflecting improvement of onboarding and training or staff.

Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. The Medical Management team will meet to discuss HCBS service plan ensuring member's eligibility for the requested services. Review of the HRA assessment and additional measuring tools define and support service plan needs. Inter rater reliability activities and training continues ongoing. The Medical Management team consists of CM Manager, BH, Social Worker, RN Case Manager and Medical Director when appropriate regarding the development of care planning and services.

Service Plan development and service authorization decisions are based on appropriateness of care and existence of coverage. Sunflower's State Health Plan Care Manager team base service authorizations on appropriateness of care and benefit coverage with the development of the member's Service Plan.

#### Role Based Security

Sunflower State Health Plan has in place role-based security to ensure no conflict of interest between the Service Plan or Plan of Care development and claims payment. Role based access control (RBAC) allows Sunflower to assign access to our Management Information Systems, in this case TruCare and Amisys Advance, to appropriately authorized personnel based on specific job roles. The claims processing team and clinical teams are two separate functional areas with different job roles and security. For Sunflower, the plans of care are developed in Kansas and the claims are processed in Great Falls, MT.

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### 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 consumer's Plan of Care (POC) utilizes information from the PD Uniform Assessment Instrument (UAI) which identifies potential risk factors. The POC will contain, 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. The POC also includes information regarding informal services and providers. It is through the POC that supports are identified that will minimize risk to the consumer and by which the State ensures the health and welfare of the consumer served under this waiver to the extent possible.

The POC is subject to periodic review and update. Reviews will take place to determine the adequacy and appropriateness of the services, and to ensure the services furnished are consistent with the nature and severity of the consumer's disability.

Emergency contact information is requested from each consumer found eligible for PD waiver services during the assessment process. This and other information obtained during the assessment and annual reassessment 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 consumer. Backup arrangements will be added to service plans and identify key elements, including specific strategies and contact persons.

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

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

Each consumer with disability found eligible for PD waiver services can choose to receive services through the waiver program or non-waiver services in a Kansas Nursing Facility. Consumers are assisted with this choice by the PD Targeted Case Manager (TCM) who outlines services provided by the waiver and by nursing facilities. The consumer's choice of service options is indicated on the Consumer Choice form provided to the consumer by the TCM. This same form is used by consumers to indicate whether or not they choose to self direct their attendant care services.

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

The State assures that each consumer found eligible for the waiver will be given free choice of all qualified providers of each service included in his/her written Plan of Care. The TCM presents each eligible consumer a list of all Targeted Case Management agencies including and payroll agencies from which the consumer can choose for self-directed services and a list of service providers for agency-directed services. The TCM assists the consumer with assessing information and supports from the consumer's preferred provider. These service access agencies have, and make available to the consumer, the names and contact information of qualified providers of the waiver services identified in the Plan of Care.

Consumers have available access to an updated list of PD waiver service access agencies at the Social and Rehabilitation Services (SRS)/Disability and Behavioral Health Services (DBHS)/Community Supports and Services (CSS) web site. This list is also made available to consumers at their annual reassessment and upon request.

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### **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 Targeted Case Manager and the consumer develop the consumer's Plan of Care from information gathered in the assessment. Once developed, that same information is submitted electronically for prior authorization to the PD Program Manager within SRS which maintains an understanding with Kansas Health Policy Authority (KHPA), the State's Medicaid agency, regarding waiver program management. Further monitoring and approval of payment for services is conducted by the Medicaid agency's fiscal agent. KHPA monitors the following through a review of data provided by SRS that is obtained through the Quality Management Strategy:

- Access to services
- Freedom of choice
- Consumers' needs met
- Safeguards in place to assure the health and welfare of the consumer are maintained
- Access to non-waiver services including State Plan services and informal supports
- Follow-up and remediation of identified programs

KHPA schedules semi-monthly policy review meetings, which include SRS waiver personnel, to discuss waiver-related issues, proposed policies and waiver amendments, as applicable. On a quarterly basis, SRS reports the findings of an in-depth quality review process conducted by SRS Regional Field Staff to KHPA. A portion of the data collected is obtained through a review of service plans to determine whether or not plans are meeting consumers' needs, including health and welfare needs. Any issues identified during the monitoring process are reported to KHPA at the monthly meetings. Steps taken to resolve issues are also presented at that time.

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### 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:*

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### 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 the Plan of Care that was developed as a partnership between the consumer and the MCO and for ensuring the health and welfare of the consumer with input from the PD 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 Plan of Care and consumer needs to ensure:

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

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

In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other

life choice decision points, or any time at the request of the consumer.

- Choice is documented.
- The Plan of Care is modified to meet change in needs, eligibility, or preferences, or at least annually.

In addition, the Plan of Care 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 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. That plan is contributed to and monitored through a state interagency monitoring team, 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 the Interagency Monitoring Team.

**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:*

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## **Appendix D: Participant-Centered Planning and Service Delivery**

### **Quality Improvement: Service Plan**

*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: Service Plan Assurance/Sub-assurances**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans that address assessed functional needs during current service year.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**PD Quality Review Process**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> KanCare MCOs contracting with Kansas.	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans that address health and safety risk factors during current service year.

**Data Source (Select one):**

Other

If 'Other' is selected, specify:

**PD Quality Review Process**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans including personal goals during current service year.

**Data Source (Select one):**

Other

If 'Other' is selected, specify:

PD Quality Review Process

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	Other Specify:

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans developed in accordance with approved policies and procedures.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PD Quality Review Process**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually	Stratified Describe Group: _____
	<input type="checkbox"/> Continuously and Ongoing	Other Specify: _____
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans which are updated/revised annually during current service year.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PD Quality Review Process**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	Weekly
<input checked="" type="checkbox"/> Operating Agency	Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PD Quality Review Process**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:
	<b>Other</b> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants that verify they have received the appropriate**

services in the type, scope, amount and frequency as specified in their individual service plan.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PD Quality Review Process

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<b>Other</b> Specify: _____

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Freedom of Choice Form PD Quality Review Process**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: _____
	<b>Other</b> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

**Performance Measure:**

Performance Standard =100%; Measure = total number of enrolled participants VS actual number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Freedom of Choice Form PD Quality Review Process**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs contracting with Kansas.	<b>Annually</b>	<b>Stratified</b> Describe Group:
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:
	<b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: KanCare MCOs contracting with Kansas.	<b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

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

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy

includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program is operationalized, staff of the three plans will be engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. Over time, the role of the MCOs in collecting and reporting data regarding the waiver performance measures will evolve, with increasing responsibility once the MCOs fully understand the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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

- i. Describe the 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.

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)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: KanCare MCOs contracting with Kansas.	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

**c. Timelines**

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

- No
- Yes

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

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