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 waiver's 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:KS.0303.R03.07**
E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/13
Approved Effective Date of Waiver being Amended: 01/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to integrate the services provided under this waiver with the State's Section 1115 KanCare Demonstration Project, effective January 1, 2013. KanCare is an integrated delivery system in which nearly all Medicaid services, including services provided under this waiver, will be provided through the KanCare health plans.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	Main 1E, 1G, 2, Tran
☑ **Appendix A – Waiver Administration and Operation**	A3, A7, Quality Perfo
☑ **Appendix B – Participant Access and Eligibility**	B3b, B6, B6e, Quality
☑ **Appendix C – Participant Services**	C-1/C-3, C.1.b, C.1.c
☑ **Appendix D – Participant Centered Service Planning and Delivery**	D1b, D1d, D2, Qualit
☑ **Appendix E – Participant Direction of Services**	Participant Direction

Component of the Approved Waiver	Subsection(s)
☑ **Appendix F – Participant Rights**	Participant Rights
☑ **Appendix G – Participant Safeguards**	G.1, G.2, G.3, Quality
☐ **Appendix H**	
☑ **Appendix I – Financial Accountability**	Amended to reflect ca
☑ **Appendix J – Cost-Neutrality Demonstration**	Amended to reflect ca

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:
  Integrate services into capitated health plans.

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
Waiver Number:KS.0303.R03.07
Draft ID: KS.06.03.11

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

E. Proposed Effective Date of Waiver being Amended: 01/01/10
Approved Effective Date of Waiver being Amended: 01/01/10

1. Request Information (2 of 3)

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

- ☐ **Hospital**

  Select applicable level of care

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

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

  Select applicable level of care

  - ◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
  - ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- ☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

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

Select one:

- ○ **Not applicable**
- ◉ **Applicable**

  Check the applicable authority or authorities:

  - ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
  - ☐ **Waiver(s) authorized under §1915(b) of the Act.**

    Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

    - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
    - ☐ **§1915(b)(2) (central broker)**
    - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
    - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
  - ☐ **A program operated under §1932(a) of the Act.**

    Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
  - ☐ **A program authorized under §1915(i) of the Act.**
  - ☐ **A program authorized under §1915(j) of the Act.**
  - ☑ **A program authorized under §1115 of the Act.**

    Specify the program:

    KanCare 1115 Demonstration Project

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The HCBS/FE waiver provides community based services an alternative to nursing facility care, to promote independence in the community setting and to ensure residency in the most integrated environment. FE services are available to individuals who are at least 65 years of age and who are financially eligible for Medicaid. Individuals must also meet the minimum FE threshold score on a functional assessment conducted by an Aging and Disability Resource Center (ADRC) acting as the State's designee. Participants are annually reassessed by an ADRC to determine if they continue to meet the level of care.

Services available through the FE waiver are: Financial Management Services, Adult Day Care, Assistive Technology, Attendant Care Services (provider agency directed or self-directed), Comprehensive Support (provider agency directed or self-directed), Home Tele health, Medication Reminder, Nursing Evaluation Visit, Oral Health Services, Personal Emergency Response, Sleep Cycle Support –Self Directed, and Wellness Monitoring.

With this amendment, FE waiver services will be provided as a part of a comprehensive package of services provided by KanCare health plans (Managed Care Organizations), and will be paid as part of a capitated rate. The health plans are responsible for assigning a case manager who will conduct a comprehensive needs assessment and develop a person-centric plan of care that includes both state plan services and, as appropriate, the FE services listed above.

The move to integrate FE waiver services into KanCare does not diminish the waiver's focus on community based services and a consumers right to choose to self-direct, provider-direct or use a combination of these delivery methods for services eligible for self-direction consumer-driven services. Consumers will continue to have a choice between consumer-directed (self-directed) services whereby they choose their attendants, or they may choose agency directed (non-self-directed) services using licensed home health agency staff as care attendants.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the

needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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 Kansas Department for Aging and Disability (KDADS) holds public hearings to allow individuals to voice opinions and express needs and concerns of the senior population.

Prior to submitting the request to amend this waiver, input was sought from stakeholders. There were discussions held regarding the impact of the changes, as well as alternatives to the proposals presented. Stakeholder input was considered and changes to the original proposals were made as a result of that feedback. Input was sought from tribal governments on November 24, 2010 and again on February 18, 2011.

In the summer of 2011, the State of Kansas facilitated a Medicaid public input and stakeholder consultation process, during which more than 1,700 participants engaged in discussions on how to reform the Kansas Medicaid system. Participants produced more than 2,000 comments and recommendations for reform. After three public forums in Topeka, Wichita and Dodge City, web teleconferences were held with stakeholders representing Medicaid population groups and providers. The State also made an online comment tool available, and a fourth, wrap-up public forum was conducted in Overland Park in August 2011.

The State carefully considered the input from this process and from meetings with advocates and provider associations. In November 2011, Kansas announced a comprehensive Medicaid reform plan that incorporated the

themes that had emerged from the public process, including integrated, whole-person care; preserving and creating paths to independence; alternative access models; and enhancing community-based services. The State conducted a formal public comment period related to the KanCare waiver application in June and July 2012. The State also conducted two rounds of tribal consultation, an initial consultation meeting in February 2012, and the second in June and July 2012, incorporating feedback from that process in its August 6 application.

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: Haverkamp

First Name: Rita

Title: State Plan and Regulations

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) 296-5107 **Ext:** ☐ **TTY**

Fax: (785) 296-4813

E-mail: Rita.Haverkamp@kdhe.ks.gov

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

Last Name:

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.

First Name: Keller

Title: Pamela

Agency: FE Program Manager

Address: Kansas Department for Aging and Disability Services

Address 2: Docking State Office Building, 9th Floor East

City: 915 SW Harrison

State: Topeka

Zip: Kansas 66612-1570

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

Fax: (785) 296-0557

E-mail: Pamela.keller@kdads.ks.gov

Signature: Elizabeth Phelps

State Medicaid Director or Designee

Submission Date: Dec 4, 2012

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

Last Name: Mosier

First Name: Susan

Title: Medicaid Director

Agency: Kansas Department of Health and Environment - Division of Health Care Finance

Address: Landon State Office Building - 9th Floor

Address 2:

City:

State:

Attachment #1: Transition Plan

Topeka

Kansas

Zip:

Phone:

66612

Fax:

(785) 296-3981 **Ext:** ☐ **TTY**

E-mail:

(785) 296-4813

smosier@kdheks.gov

Specify the transition plan for the waiver: The integration of FE waiver services into KanCare health plans will take effect January 1, 2013, with the implementation of KanCare. The change is limited to the delivery system. There is no change in eligibility for the waiver services or the scope and amount of services available to waiver participants.

The State's plan for transition of FE services to KanCare is multi-pronged:

1. Beneficiary Education and Notification; Targeted Readiness for HCBS Waiver Providers. The State has conducted extensive outreach to all Medicaid beneficiaries and providers regarding the integration of FE waivers services into KanCare. There have been five rounds of educational tours to multiple cities and towns across the state since July 2012. These tours generally included daily sessions for providers and daily sessions for beneficiaries (and usually included two different beneficiary sessions in the day – one earlier in the day and one later in the day to accommodate a wide range of schedules). Two of these tours were for all KanCare beneficiaries and providers; one focused on dental providers; and one was specifically focused on those beneficiaries and providers that have not previously been in managed care. The final tour is being conducted after member selection materials are distributed, in November 2012, designed specifically to assist beneficiaries in fully understanding their options and selecting their KanCare plan.

In addition to beneficiary education, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about 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.

Beneficiaries received notices throughout November informing them of the changes that the KanCare program will bring effective 1.1.13, pending CMS approval; advising them as to which of the three KanCare plans they had been tentatively assigned to; explaining how to make a different choice if desired; describing the relative benefits available to them under each of the three KanCare plans; describing grievances and appeals; and providing contact information for eligibility and the enrollment broker,as well as each of the KanCare plans. A further notice will be mailed in late November-early December 2012 to HCBS beneficiaries specifically, which will specifically address the how the HCBS services will transition into KanCare, how the HCBS waiver services will continue, the 180 day transition safeguard for existing plans of care, and when applicable the role of new ADRC/level of care determination contractors. The materials provided are in languages, formats and reading levels to meet enrollee needs. The State will track returned mail and make additional outreach attempts for any beneficiary whose notification is returned.

During the first 180 days of the program, the State will continue with its educational activities after initial implementation to ensure providers, beneficiaries, and stakeholders are reminded of their enrollment and choice options.

2. Efforts to Preserve Existing Provider Relationships. Wherever possible, the State has pre-assigned members to a health plan in which its existing providers are participating. Beneficiaries will be allowed to access services with existing providers during the first 90 days of implementation, regardless of whether the provider is in the plan's network. If a new plan of care

is not established in this 90 day period, this protection of both services and existing providers will continue up to either 180 days or the time a new plan of care is established. This period is extended to one year for residential service providers. For beneficiaries who do not receive a service assessment and revised service plan within the first 180 days, the health plan will be required to continue the service plan already in existence until a new service plan is created, agreed upon by the enrollee, and implemented. A member who does not receive a service assessment and revised service plan during the 90 day choice period may disenroll from his or her health plan "for cause" within 30 days of receiving a new plan of care, and select another KanCare plan managed care organization.

3. Information Sharing with KanCare Health Plans. Once the member is assigned to a health plan, the State and/or current case management entities will transmit the following data to the consumer's new MCO:
• Outstanding Prior Authorizations
• Functional assessments
• Plan of Care (along with associated providers)
• Notices of Action
• Historical claims
• Historical Prior Authorizations
This information serves as a baseline for the health plan's care management process and allows the care management team to assess the level of support and education the member may need.

4. Continuity of Services during the Transition. In order to maintain continuity of services and allow health plans time to outreach and assess the members, the State of Kansas has required the KanCare health plans to authorize and continue all existing FE services for a period of 180 days, or until a comprehensive needs assessment is completed face-to-face and a new, person centric plan of care, is developed and approved.

Also, to ensure continuity of services, the State will allow providers to continue to use the State's MMIS to enter claims. The option will ease a technical consideration of the transition for providers who do not have experience billing directly to commercial clearinghouses or other payers.

5. Intensive State Oversight. Kansas Department for Aging and Disability Services long term care licensure and quality assurance staff will provide oversight and "ride alongs" with health plan staff to ensure a smooth transition for the first 180 days. The State will review any reductions or termination of services and must approve any reduction in advance of the change.

Enrollees will have all appeal rights afforded through the MCO and state fair hearing process, including the ability to continue services during the appeal.

The State will require each health plan to maintain a call center and will review call center statistics daily. The State will also hold regular calls with each health plan to discuss key operational activities and address any concerns or questions that arise. Issues to be discussed can include, but are not limited to, network reporting and provider panel size reports, call center operations, reasons for member calls, complaint and appeal tracking, health plan outreach activities, service planning, data transfer, claims processing, and any other issue encountered during transition. The State will also review beneficiary complaints and grievances/appeals during the initial implementation on a frequent basis, and will have comprehensive managed care oversight, quality improvement and contract management.

6. Designation of an Ombudsman. There will be a KanCare Ombudsman in the Kansas Department for Aging and Disability Services. The KanCare Ombudsman helps people in Kansas who are enrolled in a KanCare plan, with a primary focus on individuals participating the HCBS waiver program or receiving other long term care services through KanCare.

The KanCare Ombudsman helps health plan members with access and service concerns, provides information about the KanCare grievance and appeal process that is available through the KanCare plans and the state fair hearing process, and assists KanCare consumers seek resolution to complaints or concerns regarding their fair treatment and interaction with their KanCare plan.

The KanCare Ombudsman will:
Help consumers to resolve service-related problems when resolution is not available directly through a provider or health plan.
Help consumers understand and resolve notices of action or non-coverage.
Assist consumers learn and navigate the grievance and appeal process at the KanCare plan, and the State fair hearing process, and help them as needed.
Assist consumers to seek remedies when they feel their rights have been violated.
Assist consumers understand their KanCare plan and how to interact with the programs benefits

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:
   Kansas Department for Aging and Disability Services/Community Services and Programs Commission

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:
• Specifies that the SSMA is the final authority on compensatory Medicaid costs.
• Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
• Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
• Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
• Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
• Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
• Specifies that the SSMA has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)
In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:
a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
• Information received from CMS;
• Proposed policy changes;
• Waiver amendments and changes;
• Data collected through the quality review process
• Eligibility, numbers of 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 face to face meeting with KDHE staff.
c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
d. Correspondence with CMS is copied to KDHE.
Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. In addition, under the KanCare program, as the HCBS waiver programs merge into comprehensive managed care, KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration will be through the KanCare Interagency Monitoring Team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are becoming part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) will be guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the KanCare Interagency Monitoring Team, which will bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including IMT meetings – 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 will be amending the KanCare QIS to include the concurrent HCBS waiver connections, and once the QIS is operational (and within 12 months of KanCare launching) will be seeking CMS approval of amendments of the HCBS waivers that embed the KanCare QIS structure.

During the first 2 weeks of implementation of KanCare, the state will hold daily calls with the MCOs to discuss any issues that arise during that day. The calls should cover all MCO operations and determine plans for correcting any issues as quickly as possible. After the first 2 weeks, if it is found that daily calls are no longer needed then the state can scale back the calls, but will maintain weekly calls for the first 90 days and bi-weekly calls for the first 180 days. After the first 180 days of the program, the state may move to the regular timeframe intended for meeting with each of the MCOs. During the initial implementation of KanCare, the state will review complaint; grievance, and appeal logs for each MCO and data from the state or MCO operated incident management system, to understand what issues beneficiaries and providers are having with each of the MCOs. The state will use this information to implement any immediate corrective actions necessary. The state will review these statistics at least weekly for the first 90 days and then at least bi -weekly for the first 180 days. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports. The state will participate in program implementation fail safe calls with CMS during the first 180 days of the demonstration. These calls will focus on all STCs in Section X of the STCs. During the first 60 days of the demonstration, these calls will be weekly and then both CMS and the state will determine the frequency of calls for the remaining 120 days. The state will provide CMS an update on all the program fail safes implemented and any issues that came up during the implementation as well as the plans to address the issues.

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 state's contracted Aging & Disability Resource Center (ADRC) conducts participant waiver assessment and level of care evaluation activities for current and potential consumers, as well as options counseling; the state's contracted Managed Care Organizations conduct plan of care development and related service authorization, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Contracted entities, including both the state's contracted ADRC providing level of care determinations (initial and redeterminations) and the state's contracted KanCare managed care organizations, are monitored through the 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. 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 the KanCare Interagency Monitoring Team, which will include 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 including oversight and monitoring of all HCBS programs and the KanCare MCOs and ADRC contractors.

The KanCare Quality Improvement Strategy and interagency agreements/monitoring teams will ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1115 waiver, Kansas statutes and regulations, and related policies. 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. Initially the MCOs will partner with KDADS field staff to conduct those reviews, and over time the MCOs will become increasingly responsible for conducting those reviews and the state will take a monitoring role in that process.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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: 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/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:
Number and percent of Quality Review Reports generated by KDADs, the state Operating agency, and the number and percent of Quality Review Reports reviewed by KDHE, the single state Medicaid agency

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of MMIS waiver policies approved by the single state Medicaid agency prior to implementation

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of Field Services Manual policy changes the single state Medicaid agency received notification of prior to implementation

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of Medicaid oversight meetings (Long-Term Care; Program Manager) held by KDHE, the single state Medicaid agency, to discuss F/E waiver issues, compared to the sixteen oversight meetings scheduled within a calendar year

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ Aged or Disabled, or Both - General					
	☑	Aged	65		☑
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

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

- [ ] **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7882
Year 2	8101
Year 3	8321
Year 4	8084
Year 5	8084

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

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Money Follows the Person (MFP)	

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):*

Money Follows the Person (MFP)

Purpose *(describe):*

The State reserves capacity for individuals transitioning from the MFP grant program to the HCBS-FE waiver. These individuals are moved onto the waiver immediately following the expiration of their MFP grant benefits.

In addition: State waiver appropriations historically have determined the number of individuals that can be served in the waiver. Funding for slots will continue to be appropriated separately for each waiver. To the extent annual appropriations remain constant or increase as savings from KanCare are realized, the State intends to increase the number of individuals served and reserves the ability to amend the waiver accordingly.

Describe how the amount of reserved capacity was determined:

MFP reserve capacity is based upon historial experience as to people who have chosen to enter the MFP program and anticipated related transitions.

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

Waiver Year	Capacity Reserved
Year 1	
Year 2	

Waiver Year	Capacity Reserved	
Year 3		
Year 4 (renewal only)		80
Year 5 (renewal only)		80

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

To be eligible for HCBS-FE waiver services, consumers (a) must be 65 years of age (b) meet the Medicaid long term care threshold; (c) be disabled according to Social Security Disability Standards; and (d) be determined functionally eligible for FE waiver services according to the FE Uniform Assessment Instrument and threshold guide level of care score (K.A.R. 30-5-305; K.A.R. 30-5-309.) Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible.

Consumers exiting a Medicaid approved nursing facility through the Money Follows the Person program, who previously gained access in this manner, will now gain access under reserve capacity.

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)

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

  Select one:

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

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

  Specify:

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

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

  Select one and complete Appendix B-5.

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

    Check each that applies:

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

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☑ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 4)

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: 727 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 4)

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 4)

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: 727 If this amount changes, this item will be revised

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

Specify formula:

- ○ **Other**

Specify:

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-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

  Specify the entity:

  Aging and Disability Resource Center (ADRC)contracting with Kansas
- ○ **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 ADRC Level of Care 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 ADRC; or a Registered Nurse license to practice in the state of Kansas. The ADRC must verify experience, education and certification requirements are met for assessors identified in 2.7.3.A2-4. The ADRC must maintain these records for five (5) years following termination of employment.
Successfully complete the Functional Assessment Instrument (FAI) and Kansas Aging Management Information System (KAMIS) training prior to performing assessments.
Assessors and interviewers must attend initial certification and recertification training sessions that cover the forms (s) the assessor or interviewer is being certified to complete.
An assessor or interviewer that has not conducted any assessments or interviews within the last six months must repeat the training and certification requirements for the functional assessment instrument that he or she will use.
KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all FAI 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
Assessors must complete 15 hours of training or continuing education annually, with an emphasis in aging and disability topics, including, but not limited to:
Annual training on the Independent Living Philosophy consisting of standardized training in history and philosophy of the National Independent Living Movement
Completion of training regarding traumatic brain injuries.
Tracking of staff training is a responsibility of the ADRC and should be recorded in the assessorâs personnel file.

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 level of care instrument/tool is the Uniform Assessment Instrument (UAI). Criteria to determine level of care are: Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), Cognition, and Risk Factors.

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 level of care criteria utilized for initial assessments of HCBS FE waiver applicants and yearly reassessments of waiver services consumers is the level of care criteria utilized by Nursing Facilities. Both applicants and current consumers must meet the Medicaid Long Term Care Threshold score based on an assessment completed with the FE Uniform Assessment Instrument (UAI). The level of care assessment and reassessment process is conducted by a qualified staff member at the Aging and Disability Resource Center contract with Kansas. Information used to determine scores and other eligibility criteria can come from a variety of sources. The consumer is the primary source of information. The ADRC uses interview techniques that are considerate of any limitations the consumer might have with hearing, eyesight, cognition, etc. Family members and other individuals who might have relevant information about the consumer can also be interviewed. The ADRC staff may also use clinical records, if available, and/or discuss the consumer's status with the appropriate medical professional.

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-evaluations are a component part of the state's contract with the ARDC. Both expectations and guidelines are specified in the waiver program's policies and procedures, which the ADRC must follow. Assurance is provided through ongoing contract monitoring and review, and quality reviews conducted by state or MCO staff.

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 ADRC. The state's contracting ADRC is using the state's KAMIS data base and the State's MIS.

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**
   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/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:
Number and percent of all new enrollees who have a level of care indicating need for institutional level of care, prior to receipt of services

Data Source (Select one):
Other
If 'Other' is selected, specify:
Kansas Aging Management Information System (KAMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Aging and Disability Resource Center (ADRC) contracting with Kansas	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial eligibility determinations made within 6 working days of intake for those applicants found eligible

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

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

	Specify:

Data Aggregation and Analysis:

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

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

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:
Percent of FE waiver participants who received an annual redetermination of eligibility within 365 days of their initial or last Level of Care evaluation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Kansas Aging Management Information System (KAMIS)

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):*
	☐ **Weekly**	☑ **100% Review**

☐ **State Medicaid Agency**		
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Aging and Disablity Resource Center (ADRC) contracting with Kansas	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

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

Data Aggregation and Analysis:

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

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/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:
Number and percentage of Level of Care (LOC) determinations made by a qualified assessor

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of initial and annual Level of Care determinations made on state's approved form (Uniform Assessment Instrument (UAI))

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Aging& Disability Resoucre Center (ADRC) contracting with Kansas
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of initial and annual Level of Care (LOC) determinations made where the LOC criteria was accurately applied

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Aging & Disability Resource Center (ADRC) contracting with Kansas
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 Aging and Disability Resource Center (ADRC) contracting 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 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 and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

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

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

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

During the plan of care development process, the KanCare MCO selected by the consumer informs eligible consumers, 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 HCBS-FE Waiver Consumer 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.

HCBS/FE Waiver Consumer Choice forms are documented and maintained by the consumer's chosen KanCare MCO in the consumer'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 Limited English Proficient (LEP) consumers 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 LEP consumers. In order to comply with federal requirements that consumers receive equal access to services provided by KDADS, and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with LEP consumers, states are required to capture language preference information. As not all currently used applications gather this information, an "Addendum to Application" has been developed. This addendum should capture the language needs of each consumer.

Each service access organization has either staff available to communicate with the consumer in his/her spoken language, accesses a phone-based translation service, or uses other interpreters for its consumers.

Appendix C: Participant Services

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

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

Service Type	Service		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Adult Day Care**		
Other Service	**Assistive Technology**		
Other Service	**Attendant Care Services - Provider Directed**		
Other Service	**Attendant Care Services - Self-Directed**		
Other Service	**Comprehensive Support - Provider Directed**		
Other Service	**Comprehensive Support - Self-Directed**		
Other Service	**Home Telehealth**		
Other Service	**Medication Reminder**		
Other Service	**Nursing Evaluation Visit**		
Other Service	**Oral Health Services**		
Other Service	**Personal Emergency Response**		
Other Service	**Sleep Cycle Support - Self-Directed**		
Other Service	**Wellness Monitoring**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Definition *(Scope):*
Financial Management Services (FMS) is provided for participants who are aging and have chosen to self-direct some or all of their services. FMS will be provided within the scope of the Agency with Choice model. The Agency with Choice is the employer option model that Kansas is making available to participants who reside in their own private residence or the private home of a family member and have chosen to self-direct some or all of their services.

Within this model the participant or participant's representative enters into a joint-employment arrangement and must work collaboratively with the FMS provider to ensure the receipt of quality, needed support services from direct support workers. The FMS provider is responsible for certain employer functions, including assisting the participant or participant's representative by providing two distinct types of tasks: (1) FMS Tasks and (2) FMS Information & Assistance (I&A) Tasks.
(1) FMS Tasks include, but are not limited to, the following:
a) Verification and processing of time worked; and the provision of quality assurance;
b) 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;
c) Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
(2) FMS Information & Assistance Tasks include, but are not limited to, the following:
a) Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
b) Assistance to the participant or participant's representative in arranging for, directing and managing services;
c) Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
d) The offer of practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct support workers, managing direct support workers, and providing effective communication and problem-solving.
The extent of the assistance furnished to the participant or participant's representative is specified in the service plan. This service does not duplicate other waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS:

•Access to this service is limited to participants or participant's representatives who direct some or all of their services.
•FMS is reimbursed per member (consumer) per month.
•Only one FMS provider is to be authorized on a Plan of Care per month.
•The participant or participant's representative may not receive payment for the administrative functions they perform.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled FMS Provider

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):*
New language for FMS services – provider qualifications – "Other Standard":
1. Each potential Agency With Choice Financial Management Service (AWC FMS) entity must complete and maintain in good standing:
a. KDADS Provider Agreement between KDADS and the FMS agency
i. Applications are available on the following website:
http://www.selfdirect.ks.gov/CaseManagersAndProviders/Pages/Forms.aspx
ii. The application must be completed and returned electronically as identified on the website.
iii. Application must be complete. Incomplete applications or the failure to provide required documentation will result in the application being pended awaiting completed documentation.
iv. KDADS Provider Agreements are valid for three (3) years; unless revoked; withdrawn or surrendered.
b. Medicaid Provider Agreement
i. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved KDADS provider agreement.
ii. Medicaid provider requirements can be located at: https://www.kmap-state-ks.us .
c. A corporation or other entity that is required to be registered with the Secretary of State's office.
i. Be in good standing with all Kansas laws/business requirements.
ii. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
iii. Businesses established to provide FMS to individuals that live in a separate household from the owner, primary operator or administrator of the FMS business.
iv. Business is established to provide FMS to more than one individual.
d. Insurance defined as:
i. Liability insurance
1) Annual liability with a $500,000 minimum
ii. Workers Compensation Insurance
1) Policy that covers all workers
2) Meets all requirements of the State of Kansas
3) Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
4) Unemployment insurance (if applicable)
5) Other insurances (if applicable)
e. Annual Independent Financial Audit:
i. Shall be contracted by all AWC FMS providers, and submitted to KDADS.
f. Demonstrate financial solvency
i. Evidence that 45 days operation costs are met (estimate of cash requirements will be estimated utilizing the past quarter's performance from the date of review; or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).
1) Cash (last three bank statements)
2) Open line of credit (statement(s) from bank/lending institution)
3) Other (explain)

g. Maintain required policies/procedures including but not limited to;
i. Policies/procedures for billing Medicaid in accordance with approved rates, and for services as authorized by POC.
ii. Policies/procedures for billing AWC FMS administrative fees
iii. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports as requested
1) Report to self-direct individuals semi-annually billing/disbursed on their behalf
2) Report to the State of Kansas as requested
iv. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and DSW) in accordance with program requirements
v. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures as established by the State of Kansas when setting direct support workers' pay rates.
1) Clear identification of how this will occur
2) Prohibition of wage/benefit setting by AWC FMS provider
3) Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/customers and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.
vi. Policies/procedures that ensure proper/appropriate process of time worked, disbursement of pay checks, filing of taxes and other associated responsibilities
vii. Policies/procedures regarding the provision of Information & Assistance services
viii. Policies/procedures for Grievance. The grievance policy is designed to assure a method that Direct Support Workers can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other AWC FMS issues.
h. Enter into a provider agreement with the KanCare MCOs to service members that have chosen those MCOs.

The Financial Management Services (FMS) Provider Agreement identifies the applicable waiver programs under which the organization is requesting to provide FMS and outlines general expectations and all specific provider requirements. Organizations interested in providing FMS are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment with the State's Fiscal Agent to provide FMS. The Secretary of KDADS (or designee) signs the agreement for the State Operating Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:
At a minimum, every three years or more frequently as deemed necessary by KDHE and KDADS.
Frequency of Verification:
At a minimum, every three years or more frequently as deemed necessary by KDHE and KDADS.

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:
Adult Day Care
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, physical) of HCBS/FE participants.
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 certain activities of daily living limited to eating, mobility and may

include transfer, bathing and dressing as identified in the Customer Service Worksheet.
This service shall not duplicate other waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS:
• Service may not be provided in the participant's own residence.
• 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 plan of care and if the provider is capable of this scope of service.
• Therapies (physical, occupational, and speech) and transportation are not covered under this service but may be covered through regular Medicaid.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	KDADS licensed free-standing Adult Day Care Facility, Nursing Facility, Assisted Living Facility, Residential Health Care Facility, and Home Plus

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. 26-43-101 et seq.
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 customers for services covered by the program.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

Service Definition *(Scope):*

Assistive technology consists of:

• Purchase of an item or piece of equipment that improves or assists with functional capabilities including, but not limited to, grab-bars, bath benches, toilet risers, and lift chairs; or

• Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings.

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

LIMITATIONS:

• Assistive Technology is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

Preliminary Questions:

(1) Does customer have family or friends within a close proximity to provide daily informal supports?
(2) Has there been an APS confirmation of self-neglect or abuse?
(3) Is the customer isolated or lives alone?
(4) Does the customer have a cognitive impairment?
What is the severity of the cognitive impairment?
(5) Is the customer in the end stages of an illness and receiving Hospice Care?
(6) Did the customer score a "4" in toileting, transferring, medication management/treatment, and walking/mobility?

CRISIS EXCEPTION – If the customer meets 5 of the 6 criteria listed above, continue with the second level of questions as follows:

(1) Does the customer meet the criteria in Preliminary Question #1?
(2) Does the customer meet the criteria in Preliminary Question #3?
(3) Has the customer had surgery in the last 30 days that resulted in a loss of functional ability or mobility?
Surgery must have been due to stroke, broken hip, or other medical incident/justification.
Please list the reason for surgery:
(4) Is the customer being discharged from NF/Hospital/Rehab?
(5) Is the Assistive Technology necessary to be received in the first 30 days of discharge to the community?
What item(s) or modification will be requested on the Assistive Technology Request Worksheet?

• All Assistive Technology (AT) purchases require prior authorization from Kansas Department for Aging and

Disability (KDADS).
• This service must be cost-effective and appropriate to the participant's needs.
• This service is limited to a lifetime maximum of $7,500.
• Assistive technology funded by other waiver programs is calculated into the lifetime maximum.
• 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 HCBS/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, HCBS/FE will cover only the difference between the standardized Medicare portion of the item and the actual purchase price.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any business, agency, or company that furnishes assistive technology items or services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Any business, agency, or company that furnishes assistive technology items or services
Provider Qualifications
License *(specify):*
K.A.R. 129-5-108
Certificate *(specify):*

Other Standard *(specify):*
K.A.R. 30-5-59
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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Attendant Care Services - Provider Directed

Service Definition *(Scope):*

Attendant care services provide supervision and/or physical assistance with Instrumental Activities of Daily Living (IADLS) and Activities of Daily Living (ADLs) for individuals who are unable to perform one or more activities independently (K.S.A. 65-6201). Attendant care services may be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

There are three levels of provider directed attendant care services, 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 Plan of Care (POC) in housing arrangements other than adult care homes. If a combination of Level I and Level II services are included in the Plan of Care, the Level II rate shall be paid if both levels of care are provided by the same provider. Level III will be utilized in the development of the POC for those participants residing in adult care homes. For Boarding Care Homes, the tasks authorized on the POC 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 customer

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.

An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a licensed nurse. A certified Home Health Aide or Certified Nurse Aide shall not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.

Medication Administration in Licensed Facilities
(K.A.R. 26-41-205 and K.A.R. 26-42-205):
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 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:
LIMITATIONS:
• Attendant must be 18 years or older
• Covered ADL and IADL services are limited as defined within the Customer Service Worksheet (CSW) and approved Plan of Care (POC)
• Attendant Care is limited to a maximum of 48 units (12 hours) per day of any combination of Provider-directed Level I, Provider-directed Level II, and Self-directed.
• Transportation is not covered with this service, but if medically necessary, it may be covered through regular Medicaid
• A customer'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 customer shall not be paid to provide Attendant Care for the customer. The only exception to this policy will be a relative who is an employee of an assisted living facility, residential health care facility, or home plus in which the customer resides and the relative's relationship is within the second degree of the customer. (See K.A.R. 26-41-101 and K.A.R. 26-42-101 for regulatory requirements.)
• 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 attendant will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet (CSW) and the case log by the case manager for a two-person lift or transfer

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Level III KDADS licensed Assisted Living Facility, Residential Health Care Facility, Home Plus
Agency	Level I Service A or B: Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Boarding Care Home
Agency	Level I Service A: Entities not licensed by DCF, KDADS or KDHE
Agency	Level I Service A: Non-medical resident care facility licensed by Department of Children and Families
Agency	Level II Service C or D: Medicare certified or KDHE licensed Home Health Agency;
Agency	Levels I & II, Services A - D: Local Health Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Provider Directed

Provider Category:
Agency
Provider Type:
Level III KDADS licensed Assisted Living Facility, Residential Health Care Facility, Home Plus
Provider Qualifications
License *(specify):*
K.S.A. 39-923 et.seq.
K.A.R. 26-39-101 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; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Provider Directed

Provider Category:
Agency
Provider Type:
Level I Service A or B: Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Boarding Care Home
Provider Qualifications
License *(specify):*
K.S.A. 65-5101 et seq.
K.S.A. 75-3307 (b)

K.A.R. 28-51-100 et seq.
K.S.A. 39-923 et.seq.
K.A.R. 26-39-101 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; recordkeeping; accept payment in full, not charge customers for services covered by the program.

Verification of Provider Qualifications

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

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Provider Directed

Provider Category:
Agency

Provider Type:
Level I Service A: Entities not licensed by DCF, KDADS or KDHE

Provider Qualifications

License *(specify):*

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.
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.
2)Written proof of liability insurance or a surety bond

Verification of Provider Qualifications

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

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Provider Directed

Provider Category:
Agency
Provider Type:
Level I Service A: Non-medical resident care facility licensed by Department of Children and Families
Provider Qualifications
License *(specify):*
K.S.A. 75-3307(b)

K.A.R. 30-42-6 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.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Provider Directed

Provider Category:
Agency
Provider Type:
Level II Service C or D: Medicare certified or KDHE licensed Home Health Agency;
Provider Qualifications
License *(specify):*
K.S.A. 65-5101 et seq.
K.S.A. 75-3307(b)
K.A.R. 28-51-100 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.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Provider Directed

Provider Category:
Agency
Provider Type:
Levels I & II, Services A - D: Local Health Department
Provider Qualifications
License *(specify):*
K.S.A. 65-5101
K.S.A. 65-5102
K.S.A. 65-5115
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; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Attendant Care Services - Self-Directed
Service Definition *(Scope):*
Attendant care services provide supervision and/or physical assistance with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) for individuals who are unable to perform one or more activities independently(K.S.A.65-6201). Attendant care services may be provided in the participant's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

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.

Participants or their representatives are given the option to self-direct their attendant care services. The participant's representative may be an individual acting on behalf of the participant, an activated durable power of attorney for health care decisions, or a guardian and/or conservator. If the participant or representative chooses to self-direct attendant care, he or she is responsible for making choices about attendant care services, including the referring for hire, supervising and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices. Self-directed attendant care is subject to the same quality assurance standards as other attendant care providers including, but not limited to, completion of the tasks identified on the Customer Service Worksheet.

According to K.S.A. 65-1124(l), a participant who chooses to self-direct their care is not required to have their attendant care supervised by a nurse. Furthermore, K.S.A. 65-6201(d) states that Health Maintenance Activities can be provided "…if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home." Health Maintenance Activities and Medication Setup must be authorized, in writing, by a physician or registered nurse (RN).

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

LIMITATIONS:

• Direct support workers must be 18 years of age or older.

• A participant who has a guardian and/or conservator cannot choose to self-direct his or her attendant care; however, a guardian and/or conservator can make that choice on the ward's behalf.

• A guardian, a conservator, a person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a participant cannot choose himself/herself as the paid direct support worker. If the designation of the appointed representative is withdrawn, the individual may become the participant's paid direct support worker after the next annual review or a significant change in the participant's needs occurs prompting a reassessment. (Please reference Field Services Manual (FSM) for additional criteria.)

• While a family member may be paid to provide attendant care, a participant's spouse shall not be paid to provide attendant care services unless one of the following criteria from K.A.R. 30-5-307 are met and prior approval is received from the KDADS FE Program Manager:

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.

• The Manage care involvement and the participant or their representative will use discretion in determining if the selected direct support worker can perform the needed services.

• Covered ADL and IADL services are limited as defined within the Customer Service Worksheet (CSW) and approved Plan of Care (POC).

• Attendant Care services are limited to a maximum of 48 units (12 hours) per day of any combination of Provider-directed Level I, Provider-directed Level II, and Self-directed.

• Transportation is not covered with this service, but if medically necessary, it may be covered through regular Medicaid.

• 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 direct support worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and case log by the case manager for a two-person lift or transfer.

• A participant residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care Home has chosen that provider as his or her selected caregiver. These housing choices supersede the self-directed care choice.

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**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled FMS Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Services - Self-Directed

Provider Category:
Agency
Provider Type:
Enrolled FMS Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be an enrolled Medicaid provider of Attendant Care Services - Self-Direct

1. Each potential Agency With Choice Financial Management Services (FMS) entity must complete and maintain in good standing:
a. KDADS Provider Agreement between KDADS and the FMS agency
i. Applications are available on the following website:
http://www.srs.ks.gov/agency/css/Pages/default.aspx or www.aging.ks.gov.
ii. The application must be completed and returned as identified on the website.
iii. Application must be complete. Incomplete applications or the failure to provide required documentation will result in the application being pended awaiting completed documentation.
iv. KDADS Provider Agreements are valid for three (3) years unless revoked, withdrawn or surrendered.
b. Medicaid Provider Agreement
i. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved SRS/KDOA provider agreement.
ii. Medicaid provider requirements can be located at: https://www.kmap-state-ks.us.
c. A corporation or other entity that is required to be registered with the Secretary of State's office.
i. Be in good standing with all Kansas laws/business requirements.
ii. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
iii. Businesses established to provide FMS to individuals that live in a separate household from the owner, primary operator or administrator of the FMS business.
iv. Business is established to provide FMS to more than one individual.
d. Insurance defined as:
i. Liability insurance
1) Annual liability with a $500,000 minimum
ii. Workers Compensation Insurance
1) Policy that covers all direct support workers
2) Meets all requirements of the State of Kansas

3) Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
4) Unemployment insurance (if applicable)
5) Other insurances (if applicable)
e. Annual Independent Financial Audit:
i. Shall be arranged for and submitted by all FMS providers.
f. Demonstrate financial solvency
i. Evidence that 30 days operation costs are met (estimate of cash requirements will be estimated utilizing the past quarter's performance from the date of review; or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).
1) Cash (last three bank statements)
2) Open line of credit (statement(s) from bank/lending institution)
3) Other (explain)
g. Maintain required policies/procedures including but not limited to:
i. Policies/procedures for verification of Medicaid billing in accordance with approved rates, and for services as authorized by POC
ii. Policies/procedures for billing FMS administrative fees
iii. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports as requested
1) Report to self-direct individuals semi-annually billing/disbursed on their behalf
2) Report to the State of Kansas as requested
iv. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and Direct Support Worker (DSW)) in accordance with program requirements
v. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures as established by the State of Kansas when setting direct support workers pay rates.
1) Clear identification of how this will occur.
2) Prohibition of wage/benefit setting by FMS provider.
3) Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/participants and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.
vi. Policies/procedures that ensure proper/appropriate processing of time worked, disbursement of paychecks, filing of paychecks, and other associated responsibilities.
vii. Policies/procedures regarding the provision of Information & Assistance services.
viii. Policies/procedures for Grievance. The grievance policy is designed to assure a method that Direct Support Workers can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other FMS issues.

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment, KDADS and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards

Frequency of Verification:

At a minimum, every three years or more frequently as deemed necessary by KDHE and KDADS.

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 - Provider Directed

Service Definition *(Scope):*

Comprehensive Support is 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.

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 to be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS:
• Comprehensive Support is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:
Is the customer a MFP Grant Program transfer? If yes, skip Preliminary Questions and proceed with second level.

Preliminary Questions:
(1) Does customer have family or friends within a close proximity to provide daily informal supports?
(2) Has there been an APS confirmation of self-neglect or abuse?
(3) Is the customer isolated or lives alone?
(4) Does the customer have a cognitive impairment?
What is the severity of the cognitive impairment?
(5) Is the customer in the end stages of an illness and receiving Hospice Care?
(6) Did the customer score a “4” in toileting, transferring, medication management/treatment, and walking/mobility?

CRISIS EXCEPTION – If the customer meets 5 of the 6 criteria listed above, continue with the second level of questions as follows:
(1) Is the customer a MFP Grant Program transfer?
(2) Is the customer in the end stages of Alzheimer’s?
(3) Does the customer suffer from a brain injury with memory loss?
(4) Does the customer require supervision for elopement that is likely to result in danger to self?

• Support worker must be 18 years of age or older.
• Comprehensive Support is limited to a maximum of 48 units (12 hours) per day 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, Home Plus, or Boarding Care 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.
• Comprehensive Support cannot be provided at the same time as HCBS/FE Attendant Care Services or HCBS/FE Sleep Cycle Support.
• 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	County Health Department
Agency	Medicare certified or KDHE licensed Home Health Agency
Agency	Entities not licensed by DCF, KDADS, or KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Comprehensive Support - Provider Directed

Provider Category:
Agency
Provider Type:
County Health Department
Provider Qualifications
License *(specify):*

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; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Comprehensive Support - Provider Directed

Provider Category:
Agency
Provider Type:
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.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.

Verification of Provider Qualifications

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

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Comprehensive Support - Provider Directed

Provider Category:
Agency

Provider Type:
Entities not licensed by DCF, KDADS, or KDHE

Provider Qualifications

License *(specify):*

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.
Entities not licensed by DCF, KDADS, or KDHE must provide the following:
1) A certified copy of its Articles of Incorporation or Articles or 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.
2) Written proof of liability insurance or surety bond

Verification of Provider Qualifications

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

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Comprehensive Support - Self-Directed

Service Definition *(Scope):*

Comprehensive Support is 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.

The direct 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 to be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

The participant's representative is given the option to self-direct the participant's comprehensive support. He/she may be an individual acting on behalf of the participant, a person authorized as an activated Durable Power of Attorney for health care decisions, or a guardian and/or conservator. If the representative chooses to self-direct Comprehensive Support, he or she is responsible for making choices about comprehensive support, including the referring for hire, supervising and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

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

LIMITATIONS:

• Comprehensive Support is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

Is the customer a MFP Grant Program transfer? If yes, skip Preliminary Questions and proceed with second level.

Preliminary Questions:

(1) Does customer have family or friends within a close proximity to provide daily informal supports?
(2) Has there been an APS confirmation of self-neglect or abuse?
(3) Is the customer isolated or lives alone?
(4) Does the customer have a cognitive impairment?
What is the severity of the cognitive impairment?
(5) Is the customer in the end stages of an illness and receiving Hospice Care?
(6) Did the customer score a "4" in toileting, transferring, medication management/treatment, and walking/mobility?

CRISIS EXCEPTION – If the customer meets 5 of the 6 criteria listed above, continue with the second level of questions as follows:

(1) Is the customer a MFP Grant Program transfer?
(2) Is the customer in the end stages of Alzheimer's?
(3) Does the customer suffer from a brain injury with memory loss?
(4) Does the customer require supervision for elopement that is likely to result in danger to self?

• Direct support workers must be 18 years of age or older

• Comprehensive Support is limited to a maximum of 48 units (12 hours) per day to occur during the participant's normal waking hours. Comprehensive Support in combination with other FE waiver services cannot exceed 24 hours per day
• A participant who has a guardian and/or conservator cannot choose to self-direct his or her comprehensive support; however, a guardian and/or conservator can make that choice on the ward's behalf
• 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
• The Manage care involvment and the participant or their representative will use discretion in determining if the selected direct support worker can perform the needed services
• Participants residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or a Boarding Care Home are not eligible to self-direct this service
• 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
• Comprehensive Support cannot be provided at the same time as HCBS/FE Attendant Care Services or HCBS/FE Sleep Cycle Support
• 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)*:

- [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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled FMS Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Comprehensive Support - Self-Directed

Provider Category:
Agency
Provider Type:
Enrolled FMS Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be an enrolled Medicaid provider of Comprehensive Support - Self-Direct

1. Each potential Agency With Choice Financial Management Services (FMS) entity must complete and maintain in good standing:

a. KDADS Provider Agreement
i. Applications are available on the following website:
http://www.srs.ks.gov/agency/css/Pages/default.aspx or www.aging.ks.gov.
ii. The application must be completed and returned as identified on the website.
iii. Application must be complete. Incomplete applications or the failure to provide required documentation will result in the application being pended awaiting completed documentation.
iv. KDADS Provider Agreement between KDADS and the FMS agency
Agreements are valid for three (3) years unless revoked, withdrawn or surrendered.
b. Medicaid Provider Agreement
i. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved SRS/KDOA provider agreement.
ii. Medicaid provider requirements can be located at: https://www.kmap-state-ks.us.
c. A corporation or other entity that is required to be registered with the Secretary of State's office.
i. Be in good standing with all Kansas laws/business requirements.
ii. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
iii. Businesses established to provide FMS to individuals that live in a separate household from the owner, primary operator or administrator of the FMS business.
iv. Business is established to provide FMS to more than one individual.
d. Insurance defined as:
i. Liability insurance
1) Annual liability with a $500,000 minimum
ii. Workers Compensation Insurance
1) Policy that covers all direct support workers
2) Meets all requirements of the State of Kansas
3) Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
4) Unemployment insurance (if applicable)
5) Other insurances (if applicable)
e. Annual Independent Financial Audit:
i. Shall be arranged for and submitted by all FMS providers.
f. Demonstrate financial solvency
i. Evidence that 30 days operation costs are met (estimate of cash requirements will be estimated utilizing the past quarter's performance from the date of review; or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).
1) Cash (last three bank statements)
2) Open line of credit (statement(s) from bank/lending institution)
3) Other (explain)
g. Maintain required policies/procedures including but not limited to:
i. Policies/procedures for verification of Medicaid billing in accordance with approved rates, and for services as authorized by POC
ii. Policies/procedures for billing FMS administrative fees
iii. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports as requested
1) Report to self-direct individuals semi-annually billing/disbursed on their behalf
2) Report to the State of Kansas as requested
iv. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and Direct Support Worker (DSW)) in accordance with program requirements
v. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures as established by the State of Kansas when setting direct support workers pay rates.
1) Clear identification of how this will occur.
2) Prohibition of wage/benefit setting by FMS provider.
3) Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/participants and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.
vi. Policies/procedures that ensure proper/appropriate processing of time worked, disbursement of paychecks, filing of paychecks, and other associated responsibilities.
vii. Policies/procedures regarding the provision of Information & Assistance services.
viii. Policies/procedures for Grievance. The grievance policy is designed to assure a method that Direct Support Workers can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other FMS issues.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Definition *(Scope):*

Home telehealth is a remote monitoring system provided to a customer that enables the customer to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the customer's health declines. The provision of home telehealth entails customer education specific to one or more diseases, counseling, and nursing supervision.

Home telehealth automates disease management activities, and engages customers with personalized daily interactions and education to build or expand the customer's self-management behaviors. The service will enable telehealth providers, after determining the customer's progress, to motivate behavior changes through user-friendly technology, helping customers meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.

The provider will access the telehealth system to review each customer's baseline, defined by the customer's physician at enrollment, trended survey responses, and vital sign measurements. A licensed nurse will monitor the health status of multiple customers, and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional.

Customers qualify for this service if the customer:

• 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 Money Follows the Person to move from a nursing facility back into the community.

The provider must train the customer and caregiver on use of the equipment. The provider must also ensure ongoing customer education specific to one or more diseases, counseling, and nursing supervision. Customer education shall include such topics as learning symptoms to report, the disease process, risk factors, and other relevant aspects relating to the disease.

HCBS/FE home telehealth services is not a duplication of Medicare telehealth services. While the Kansas legislature calls this service home telehealth, the actual service follows the CMS telemonitoring definition which Medicare does not cover. HCBS/FE home telehealth is a daily monitoring of the customer's vital sign measurements from the customer's home setting to prevent a crisis episode; whereas Medicare telehealth includes specific planned contacts for professional consultations, office visits, and office psychiatry services, usually through video contact.

During KDADS's plan of care approval process, KDADS will confirm there is no prior authorization for Medicaid home telehealth skilled nursing visits in the Medicaid Management Information System (MMIS). If a prior authorization is identified, HCBS/FE home telehealth services will be denied.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS:
• Registered Nurse (RN) or licensed practical nurse with RN supervision to set up/supervise/ provide customer counseling
• Customer 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 customer contact to reinforce positive self-management behaviors
• If customer fails to perform daily monitoring for seven (7) consecutive days, case manager must be notified to determine if continuation of the service is appropriate.
• Customers 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	County Health Department; Medicare certified or KDHE licensed Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Telehealth

Provider Category:
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 customer's diagnosis. The provider and equipment must have needed language options – e.g. English/Spanish/Russian/Vietnamese.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:

As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medication Reminder

Service Definition *(Scope):*

Provides a scheduled reminder to a participant when it's time for him/her to take medications. The reminder may be a phone call, an automated recording, or an automated alarm, depending on the provider's system.

This service does not duplicate other waiver services.

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

LIMITATIONS:

• 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 is limited to those participants who live alone, or who are alone a significant portion of the day in residential settings, and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
• 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.
• This service is available in the participant's place of residence, excluding adult care homes.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medication Reminder Co; Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; and Emergency Medical Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medication Reminder

Provider Category:
Agency
Provider Type:
Medication Reminder Co; Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; and Emergency Medical Services
Provider Qualifications
License *(specify):*
K.S.A. 65-425 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 28-34-2
K.A.R. 28-51-100 et seq.
Certificate *(specify):*

Other Standard *(specify):*
K.S.A. 65-6112 et seq.describes emergency medical 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 customers for services covered by the program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Nursing Evaluation Visit
Service Definition *(Scope):*
A Nursing Evaluation Visit is different from the initial assessment that is used to develop the Plan of Care (POC). Nursing Evaluation Visit is a service provided only to participants that receive Level II Attendant Care Services through a Home Health Agency, Assisted Living Facility, Residential Health Care Facility, or other licensed entity. Nursing Evaluation Visits are conducted by an RN employed by the provider of Level II Attendant Care Services. During the Nursing Evaluation Visit, the RN determines which attendant may best meet the needs of the participant, and any special instructions/requests of the participant regarding delivery of services.
This service includes an initial face-to-face evaluation visit by an RN, one time, per participant, per provider.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS:
• A Nursing Evaluation Visit will need to be completed for a participant who needs provider-directed Attendant Care Services Level II.
• 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.
• This service must be provided by an RN employed by, or a self-employed RN contracted by, the Attendant Care Level II provider.

• A Nursing Evaluation Visit is not conducted when a participant chooses to self-direct Attendant Care Services.
• The RN is responsible for submitting a written report to the manage care involvement within two weeks of the visit. This report will include any observations or recommendations the nurse may have relative to the participant which were identified during the Nursing Evaluation Visit.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-Employed Registered Nurse licensed in Kansas
Agency	County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus

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 Type:
Self-Employed Registered Nurse licensed in Kansas
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
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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. 26-39-101
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; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Oral Health Services
Service Definition *(Scope):*
Oral Health Services shall mean accepted dental procedures, to include diagnostic, prophylactic, and restorative care, and allow for the purchase, adjustment, and repair of dentures, which are provided to adults (age 65 and older) who are enrolled in the HCBS Frail Elderly waiver. Anesthesia services provided in the dentist's office and billed by the dentist shall be included within the definition of oral health services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS:
• Oral Health Services are limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception in accordance with the established KDOA policies and guidelines.

Crisis exception criteria:
(1) Did the customer have a treatment plan in place prior to 1/1/2010?
What point is the dentist at in working with the customer on the total oral procedure/plan?

(2) Does the customer require emergency treatment to resolve an oral health issue that is life threatening?

(3) How will non-treatment of the oral health issue impact the customer?

• To avoid duplication of services, Oral Health Services only include needed services not covered by regular State Plan Medicaid, and are limited to those services which cannot be procured from other formal or informal resources such as community donations received by the case management entity to use toward oral health services, other formal programs funded from state general funds, and Medicare 65 plans.
• Services shall not include outpatient or inpatient facility care.
• Orthodontic and implant services are not covered.
• Complete or partial dentures are allowed once every 60 months.
• 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Clinic with individuals licensed as a dentist or dental hygienist
Individual	Dentist or Dental Hygienist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Oral Health Services

Provider Category:
Agency
Provider Type:
Clinic with individuals licensed as a 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.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response
Service Definition *(Scope):*
Diagnosis alone does not determine need for this service. The MCO Care Coordinator authorizes the need for this service based on an underlying medical or functional impairment.

This service does not duplicate other waiver services.

Personal Emergency Response units are electronic devices and have portable buttons worn by the participant. These units provide 24 hour a day on-call support to a participant having a medical or emergency need that could become critical at anytime.
Examples include:
Potential for Injury; Cardiovascular Condition; Diabetes; Convulsive Disorders; Neurological Disorders; and Respiratory Disorders
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

LIMITATIONS:
• 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
• This service is limited to those participants who live alone, or who are alone a significant portion of the day in residential settings, and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision
• 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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; KDADS licensed NF, ALF, RHCF, Home Plus; and Emergency Medical Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response

Provider Category:
Agency
Provider Type:
Personal Emergency Response Co; Medicare certified or KDHE licensed Home Health Agency; KDHE licensed Hospital; KDADS licensed NF, ALF, RHCF, Home Plus; and Emergency Medical Services
Provider Qualifications
License *(specify):*
K.S.A. 39-923 et seq.
K.S.A. 65-425 et seq.
K.S.A. 65-5101 et seq.
K.A.R. 26-39-101
K.A.R. 28-34-2
K.A.R. 28-51-100 et seq.
Certificate *(specify):*

Other Standard *(specify):*
K.S.A. 65-6112 et seq.describes emergency medical 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 customers for services covered by the program.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Sleep Cycle Support - Self-Directed

Service Definition *(Scope):*

This service provides non-nursing physical assistance and/or supervision during the participant's normal sleeping hours in the participant's place of residence, excluding adult care homes. This service includes physical assistance or supervision with toileting, transferring and mobility, and prompt and reminding of medication. This service shall not duplicate other waiver services.

Direct support worker may sleep but must awaken as needed to provide assistance as identified in the participant's service plan. Direct support worker must provide the participant a mechanism to gain their attention or awaken them at any time. Direct support worker must be ready to call a physician, hospital or other medical personnel should an emergency arise. Direct support worker must submit a report to the manage care involvement within the first business day following any emergency response provided the participant.

Sleep Cycle Support is a self-directed service. The participant or representative is responsible for making choices about sleep cycle support, including the referring for hire, supervising and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

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

LIMITATIONS:

• Sleep Cycle Support is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.

Crisis exception criteria:

Is the customer a MFP Grant Program transfer? If yes, skip Preliminary Questions and proceed with second level.

Preliminary Questions:

(1) Does customer have family or friends within a close proximity to provide daily informal supports?
(2) Has there been an APS confirmation of self-neglect or abuse?
(3) Is the customer isolated or lives alone?
(4) Does the customer have a cognitive impairment?
What is the severity of the cognitive impairment?
(5) Is the customer in the end stages of an illness and receiving Hospice Care?
(6) Did the customer score a "4" in toileting, transferring, medication management/treatment, and walking/mobility?

CRISIS EXCEPTION – If the customer meets 5 of the 6 criteria listed above, continue with the second level of questions as follows:
(1) Is the customer a MFP Grant Program transfer?
(2) Does the customer have a documented health and welfare need?
If yes, provide a doctor's letter that explains specifically how and in what way there is a health and welfare need.
Health and welfare need would include bedridden and requiring turning or toileting; certain medical interventions.
Please specify what the need is and what medical intervention is needed.

• Direct support workers must be 18 years of age or older.
• Period of service must be at least six hours in length but cannot exceed a twelve hour period of time.
• Only one unit is allowed within a 24-hour period of time.
• Sleep Cycle 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 Sleep Cycle Support for the participant.
• Participants residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care are not eligible for this service.
• Direct support worker must have a permanent residence separate and apart from the participant.
• The manage care involvement and the participant or their representative will use discretion in determining if the selected direct support worker can perform the needed services.
• 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)*:

- [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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled FMS Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sleep Cycle Support - Self-Directed

Provider Category:
Agency
Provider Type:
Enrolled FMS Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be an enrolled Medicaid provider of Sleep Cycle Support

1. Each potential Agency With Choice Financial Management Services (FMS) entity must complete and maintain in good standing:
a. KDADS Provider Agreement
i. Applications are available on the following website:
http://www.srs.ks.gov/agency/css/Pages/default.aspx or www.aging.ks.gov.
ii. The application must be completed and returned as identified on the website.
iii. Application must be complete. Incomplete applications or the failure to provide required documentation will result in the application being pended awaiting completed documentation.
iv. SRS/KDOA Provider Agreements are valid for three (3) years unless revoked, withdrawn or surrendered.
b. Medicaid Provider Agreement
i. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved SRS/KDOA provider agreement.
ii. Medicaid provider requirements can be located at: https://www.kmap-state-ks.us.
c. A corporation or other entity that is required to be registered with the Secretary of State's office.
i. Be in good standing with all Kansas laws/business requirements.
ii. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
iii. Businesses established to provide FMS to individuals that live in a separate household from the owner, primary operator or administrator of the FMS business.
iv. Business is established to provide FMS to more than one individual.
d. Insurance defined as:
i. Liability insurance
1) Annual liability with a $500,000 minimum
ii. Workers Compensation Insurance
1) Policy that covers all direct support workers
2) Meets all requirements of the State of Kansas
3) Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
4) Unemployment insurance (if applicable)
5) Other insurances (if applicable)
e. Annual Independent Financial Audit:
i. Shall be arranged for and submitted by all FMS providers.
f. Demonstrate financial solvency
i. Evidence that 30 days operation costs are met (estimate of cash requirements will be estimated utilizing the past quarter's performance from the date of review; or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).
1) Cash (last three bank statements)
2) Open line of credit (statement(s) from bank/lending institution)
3) Other (explain)
g. Maintain required policies/procedures including but not limited to:
i. Policies/procedures for verification of Medicaid billing in accordance with approved rates, and for services as authorized by POC
ii. Policies/procedures for billing FMS administrative fees
iii. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports as requested
1) Report to self-direct individuals semi-annually billing/disbursed on their behalf
2) Report to the State of Kansas as requested
iv. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and Direct Support Worker (DSW)) in accordance with program requirements
v. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures as established by the State of Kansas when setting direct support workers pay rates.
1) Clear identification of how this will occur.
2) Prohibition of wage/benefit setting by FMS provider.
3) Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/participants and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.
vi. Policies/procedures that ensure proper/appropriate processing of time worked, disbursement of

paychecks, filing of paychecks, and other associated responsibilities.
vii. Policies/procedures regarding the provision of Information & Assistance services.
viii. Policies/procedures for Grievance. The grievance policy is designed to assure a method that Direct Support Workers can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other FMS issues.

Verification of Provider Qualifications

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

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Wellness Monitoring

Service Definition *(Scope):*
This service provides a Wellness Monitoring visit through nursing assessment by a licensed nurse. This service provides an opportunity for the nurse to check a participant's health concerns that have been identified by the manage care involvement. This service reduces the need for routine physician/health professional visits and care in more costly settings. Any changes in the health status of the participant during the visits are then brought to the attention of the manage care involvement and the physician as needed. A written report must be sent to the Manage care involvement documenting the participant's status within two (2) weeks of the nurse visit.

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.

This service shall not duplicate other waiver services.

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

•Wellness monitoring is limited to one face-to-face visit every 55 days, or less frequently, as determined by the MCO Care Coordinator.
•Wellness Monitoring requires a written follow-up report within two weeks of the face-to-face visit by the licensed nurse. This report will be sent to the manage care involvement regarding the findings and recommendation of the licensed nurse.

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

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

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	County Health Department; Medicare certified or KDHE licensed Home Health Agency; KDADS licensed Assisted Living Facility, Residential Health Care Facility, and Home Plus
Individual	Self-employed Registered Nurse licensed in Kansas

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:
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. 26-39-101
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; recordkeeping; accept payment in full, not charge customers for services covered by the program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs
Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Monitoring

Provider Category:
Individual
Provider Type:
Self-employed Registered Nurse licensed in Kansas
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; recordkeeping; accept payment in full, not charge customers for services covered by the program.

Verification of Provider Qualifications

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

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

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

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

- (●) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ( ) **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - [ ] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - [ ] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - [ ] **As an administrative activity.** *Complete item C-1-c.*

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):

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):

Appendix C: Participant Services

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

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

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- (●) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Non-medical Resident Care Facility	

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

The facility environment is designed to be as homelike as possible with separate areas for living, dining, activities, and resident privacy. Residents are encouraged to participate in congregate dining, have access to a full kitchen with opportunities to share in meal preparations, have available outdoor activity space, and community activities available for their participation. Residents may come and go freely and have visitors at any time.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Non-medical Resident Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response	☑
Sleep Cycle Support - Self-Directed	☐

Waiver Service	Provided in Facility
Oral Health Services	☐
Home Telehealth	☐
Adult Day Care	☐
Wellness Monitoring	☑
Financial Management Services	☐
Assistive Technology	☑
Attendant Care Services - Provider Directed	☑
Comprehensive Support - Provider Directed	☑
Nursing Evaluation Visit	☐
Comprehensive Support - Self-Directed	☐
Attendant Care Services - Self-Directed	☐
Medication Reminder	☑

Facility Capacity Limit:

40

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

Scope of State Facility Standards

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

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

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.*

According to KAR 30-5-307, Family reimbursement restriction: (a) Neither an adult consumer's spouse nor a minor consumer's parent shall be paid to provide HCBS services to that consumer, unless 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 do not have any additional limitations of service provision. Services and payments for rendered services are monitored by the Manage care involvement assigned. Post payment review is done through the MMIS payment system.

Under no circumstances shall a spouse be paid to provide comprehensive support or sleep cycle support.

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, provided they are not the participant's spouse or legal guardian, may provide the following HCBS/FE services to the participant:
• Attendant Care - Self-Direct
• Comprehensive Support - Self-Direct

• Sleep Cycle Support - Self-Direct

NOTE: Under limited circumstances, a spouse may be approved to provide Attendant Care-Self Direct. (See KAR 30-5-307)

Additional limitations to Attendant Care, Self-Direct include:
• Direct support worker must be 18 years of age or older.
• A participant who has a guardian and/or conservator cannot choose to self-direct his or her attendant care; however, a guardian and/or conservator can make that choice on the ward's behalf.
• The Manage care involvement and the participant or their representative will use discretion in determining if the selected direct support worker can perform the needed services.
• A guardian, a conservator, a person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a participant cannot choose himself/herself as the paid direct support worker. If the designation of the appointed representative is withdrawn, the individual may become the participant's paid direct support worker after the next annual review or a significant change in the participant's needs occurs prompting a reassessment. (Please reference Field Services Manual (FSM) for additional criteria.) The provision of services must be in the best interest of the participant.

Additional limitations to Comprehensive Support include:
• Direct support workers must be 18 years of age or older.
• A participant who has a guardian and/or conservator cannot choose to self-direct his or her comprehensive support; however, a guardian and/or conservator can make that choice on the ward's behalf.
• 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.
• The manage care involvement and the participant or their representative will use discretion in determining if the selected direct support worker can perform the needed services.
• An individual providing Comprehensive Support must have a permanent residence separate and apart from the participant.

Additional limitations to Sleep Cycle Support also include:
• Direct support workers must be 18 years of age or older.
• Providers of this service must have a permanent residence separate and apart from the participants.
• 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 Sleep Cycle Support for the participant.
• The manage care involvement and the participant or their representative will use discretion in determining if the selected direct support worker can perform the needed services.

Monitoring and control of all services are provided by manage care involvement oversight and the post payment review in the MMIS payment system.

○ **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:

Consumers of HCBS-FE 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 (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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: 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/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:
      Percent of new FE waiver provider enrollments (by provider type) that initially met licensure requirements, certification requirements, and other standards prior to furnishing waiver services

      Data Source (Select one):
      Other
      If 'Other' is selected, specify:
      Provider application and supporting documentation

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

☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare MCOs contracting with Kansas	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure/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:
Percent of new non-licensed FE waiver provider enrollments that have met the waiver requirements

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider application and supporting documentation

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

Data Aggregation and Analysis:

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

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

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

For each performance measure/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:
Number and percentage of FE waiver direct service providers that provided required training for their staff

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: EDS, the fiscal agent KanCare MCOs contracting with Kansas	☐ **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 uses an ongoing survey and evaluation process to verify that proiders continue to meet licensing and /or certification standards and adhere to otherState standards. Adult care home 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 the KDHE. Both agencies utilize a similar process to evaluate providers. By statute, the aveerage 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 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 request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
○ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
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 developmenting, 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.

Regarding Amerigroup: Service plans for Amerigroup members in waivers are developed by Service Coordinators who must have at least two years of experience working with individuals with chronic illness, comorbidities, and/or disabilities in a Service Coordinator, Case Management, Advocate or similar role. Preferred qualifications include experience in home health, health care, discharge planning, behavioral health, collaborating with nursing facilities, community resources, and/or other home and community-based agencies. Experience working with Medicare, Medicaid and managed care programs is also preferred.

While a Masters degree is preferred, education/experience for Service Coordinators must include one of the following
• Bachelors degree from an accredited college or university in Nursing, Social Work, Counseling, Special Education, Sociology, Psychology, Gerontology, or a closely related field, or State Waiver;
• Bachelors Degree in an unrelated field and at least two years of geriatric experience; or
• In lieu of a bachelor's degree, six years of case management experience

Regarding Sunflower: Sunflower employs an Integrated Care Team approach for Service Plan Development. Teams conducting care coordination/care management are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers have primary responsibilty 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. Each Member receiving Care Management is assigned a lead Care Manager who oversees the Member's care. This includes, but is not limited to, participation in inpatient rounds with concurrent review nurses to assist with discharge and transitional care planning, and coordination with the Member's treating providers. Care Managers perform assessments, work with Members/caregivers to develop care plans, and provide educational resources and follow up in conjunction with the Integrated Care Team.

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.

When an individual is 65 years of age an older is determined eligible for services in a Nursing Facility, the member's chosen KanCare MCO provides certain information and support to the consumer regarding available services and the plan development process. The MCO: (1) provides information to the consumer and/or his/her legal representative regarding alternate service options available through the FE 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, 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.

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):

All applicants for FE waiver services must undergo an assessment to determine functional eligibility for the waiver. The first two (2) pages of the FE 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 FE waiver services is determined eligible for services and indicates his/her choice to receive home and community based services.
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.

The Service Plan is developed by the participant, the MCO and any selected representatives that the participant chooses to be involved. The location is normally in the customer's home but arrangements can be made for another location if the customer desires (e.g. hospital, nursing home, adult day care day). Date and time is always coordinated based on the convenience of the customer and the customer's representative, if applicable. The plans begin within seven (7) working days of financial and functional eligibility determination. Services provided are based upon the needs of the participant identified through the assessment process as noted on the Uniform Assessment Instrument (UAI), Customer Service Worksheet (CSW), and Plan of Care (POC).

With the participant's approval, family members or other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development and implementation of the POC. 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 POC. The participant's desired outcomes and preferences are discussed when determining the services to be included in the POC.

When there are other individuals living in the home in which the customer resides, the meal preparation, shopping and laundry/housekeeping must be provided as an informal support and documented on the CSW and POC. If the individual(s) refuses or is unable to perform any of the above tasks and this is documented in the customer's case file, these services may be provided formally by an individual not residing tin the home. Under no circumstances will an individual living in the home be reimbursed for performing these tasks.
The MCO and the customer or customer's representative must identify the services that are currently provided through informal supports. These services must continue to be provided informally and documented as such on the CSW and POC. If the individual (s) refuses or is unable to perform any of these tasks and this is documented in the customer's case file, these services may be provided formally by an agency.
The MCO completes the appropriate forms indication service tasks necessary to enable the participant to live safely in the most integrated environment possible. A physician's statement may be required if there is any question about physical disabilities or limitations. A physician's statement is required if the participant elects to self-direct attendant care and requires health maintenance tasks or medication set-up.

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

The MCO updates and lists all services received by the participant on the POC. The MCO shall document all services being provided to a participant including formal and informal services (e.g., provided by volunteers, family church, neighbors, peers, or other service agency). For each service change the POX must be signed or resigned by both the MCO and the participant or participant's representative
The MCO shall record all pertinent information received verbally or in writing from the participant, staff or collateral contacts in the case log.
the MCO shall send the CSW, POC, and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated durable power of attorney, guardian, and conservator.

In addition, when a participant chooses HCBS/FE and lives in an Assisted Living Facility (ALF), Residential Health Care Facility (PHCF), or Home Plus (HP), the TCM must do the following: encourage the participant to negotiate the room and board costs with the facility Screen with the facility staff for consistency with the development of the CSW and POC: review the Negotiated Service Agreement to identify the tasks the facility will provide within the room and board charge, and sign if needed: develop the POC with the participant and the facility staff based on needs identified using the UAI and CSW; and ensure that all required parties have signed the POC after completion.

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

As part of the transition to the KanCare comprehensive managed care program, Kansas has worked with CMS to identify and utilize some transition safeguards for people using HCBS waiver services. Those safeguards are detailed in the Special Terms and Conditions associated with the 1115 KanCare program, and are summarized here as follows:
a. For beneficiaries with no service assessment and revised service plan implemented within the first 180 days, the MCO will be required to continue the service plan already in existence for both service level and providers used until a new service plan is created, agreed upon by the enrollee, and implemented.
b. MCO to prioritize initial assessments and service planning to those individuals whose service plans expire within the first 90 or 180 days or whose needs change and necessitate a new service plan
c. Beneficiary allowed to access all LTSS providers on their current service plan on a non-par basis for up to 180 days, 1 year for residential providers, or until a new service plan is agreed to and implemented (whichever is sooner). The new MCOs will make a priority to either get those providers in-network or focus on finding a new provider of that service for the beneficiary.
d. For the first 180 days of the KanCare program, State will review and approve all plans of care that have a reduction, suspension, or termination in services prior to the service plan being put in place. The enrollee will also have all appeal rights afforded through the MCO and state fair hearing process and the ability to continue services

during the appeal.
e. State will complete "ride-alongs" with MCO case managers during the first 180 days to assess MCO compliance with service assessment and planning. State to report to CMS on the outcome of the ride-alongs.
Safeguards related to mitigating conflict of interest in the development of service plans:
Kansas retains the responsibility for both initial and annual eligibility determinations for all HCBS programs, which Kansas will conduct via contractors or providers with state oversight. 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 developmenting, 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. During the initial 180 day transition period, 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 90 days according to the existing plan, or up to 180 days/until a new assessment is completed by health plan care coordinators (whichever occurs first). 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 directed by the state, 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.

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.

Risks are captured in the Uniform Assessment Instrument (UAI). These risks include falls, behaviors, support systems, cognitive status, abuse, neglect, and exploitation. These issues are addressed in both the development of the Plan of Care (POC) and Customer Service Worksheet (CSW). Identified risks are discussed with the participant and participant representatives. All participants are required to have a back-up plan for staffing requirements and emergency situations to mitigate the risk of not receiving services as outlined on the POC.

Participants are assessed on each risk, and service options are discussed and implemented, as needed, based on risk. Resources are available to meet participant needs for assistive equipment. State licensure requires that Home Health Agencies have back-up staff available to provide services and state regulations require that assisted living facilities, residential health care facilities, and homes plus have a written emergency management plan. If the participant chooses to self-direct, the participant is accountable for having staff available to meet their care needs.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each consumer 65 years of age and older found eligible for FE 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 each consumer's chosen KanCare MCO, 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 MCO. 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 MCO 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 MCO presents each eligible consumer a list providers from which the consumer can choose for self-directed services and a list of service providers for agency-directed services. The MCO 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 FE waiver service access agencies at the Kansas Department for Aging and Disability Services/Community Services and Programs Commission(KDADS) web site. This list is also made available to consumers at their annual reassessment and upon request.

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):

Individuals seeking community-based services are assessed by ADRC using the Uniform Assessment Instrument (UAI). If the Long-term Care threshold is met Medicaid service options are discussed with the participant, including admission to a nursing facility and Home and Community-Based Services for the Frail Elderly (HCBS/FE). If the participant does not meet the Medicaid threshold, the ADRC discusses private-pay admission to a nursing facility or

community services with the participant. Participants deciding on HCBS/FE services who meet the Medicaid functional threshold and Medicaid financial eligibility will be referred to the customer's chosen MCO. The participant can accept or decline services at this point.
The customer's chosen MCO and the customer develop the customer Plan of Care from information gathered in the assessment. For the first 180 days of the transition to the KanCare program, any reduction in HCBS services on a consumer's plan of care must be reviewed and approved by the state. Further monitoring of services is conducted by the state consistent with the comprehensive KanCare quality improvement strategy. Included in that strategy is review of data that addresses:

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

A critical component of that strategy is the engagement of the KanCare Interagency Monitoring Team, 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The 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:*

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:
Number and percent of FE waiver participants who have Service Plans that address their needs and capabilities as indicated in the assessment

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of FE waiver participants observed by KDADS Quality Review staff to have no unmet needs

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of FE waiver participants who have a disaster red flag designation with a related disaster back-up plan

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☑ **Other** Specify:	☐ **Annually**	☐ **Stratified**

KanCare MOCs contracting with		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State 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:

Percent of FE waiver participants whose Service Plan was based on information obtained and documented in a complete Uniform Assessment Instrument (UAI)

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of FE waiver participants whose Service Plan was started within the number of days specified in the FE waiver application

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of Service Plans with appropriate participant and Management entity involvment

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial and updated Service Plans with Management entity involvement

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

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

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

Data Aggregation and Analysis:

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

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:
Percent of Service Plans reviewed before the FE waiver participant's annual redetermination date

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of FE waiver participants with documented change in needs whose Service Plan was revised, as needed, to address the change

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

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

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☑ **Other** Specify: KanCare MCOs contracting with Kansas	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
Percent of FE waiver participants reporting all services in the Service Plan received

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of FE waiver participants reporting that attendants/workers worked the amount of time authorized on the Service Plan

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of attendants/workers who FE waiver participants reported being to work on time

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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:
Percent of FE waiver participants whose record contains a Customer Choice form indicating a choice of community-based services versus nursing facility care

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of FE waiver participants whose record contains a Customer Choice form indicating choice of either self-directed or agency-directed care

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of FE waiver participants whose record contains Customer Choice form indicating choice of waiver service providers

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of FE waiver participants or participants' representatives that have signed the most recent plan of care indicating choice of waiver services

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

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

Specify:

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS 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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs contracting with Kansas.	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.
WORK PLAN:

Operating agency will add questions to Quality Review Protocol to monitor performance measures for service plans by July 2010

Operating agency will require data entry of disaster red flag in KAMIS to monitor participant back-up plans by March 2010

Operating agency will redesign Customer Service Worksheet to incorporate Customer Disaster Resource Plan by March 2010

Operating agency will implement a tracking and reporting system for Quality Review's Referral and Response form to include MCO, unmet need, reason, and outcome by July 2011

Operating agency will develop a performance measure using the quality review process to review provider claims and documentation as compared to the service plan by July 2011

Operating agency will revise the Quality Review process for reviewing provider claims and supporting documentation as compared to the service plan by July 2011

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 consumers of FE 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 Direct Service worker is made known to the consumer by the MCO, which is available to all waiver consumers (Kansas Statute 39-7,100).
This opportunity includes specific responsibilities required of the consumer, including:
• Recruitment and selection of Direct Service worker), back-up DSWs 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 consumer's chosen FMS provider;
• Provider orientation and training;
• Maintenance of continuous service coverage in accordance with the Plan of Care, 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) Consumers are provided with information about self-direction of services and the associated responsibilities by the MCO during the service planning process. Once the consumer is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Consumer Choice form and included in the consumer's Plan of Care.
The MCO assists the consumer with identifying an FMS provider and related information is included in the consumer's Plan of Care. The MCO supports the consumer who selects self-direction of services by monitoring services to ensure that they are provided by Personal Care Attendants and Sleep Cycle Support attendants in accordance with the Plan of Care and the Attendant Care Worksheet, which are developed by the consumer with assistance from the MCO. The MCO also provides the same supports given to all waiver consumers, including Plan of Care updates, referral to needed supports and services, and monitoring and follow-up activities.
c) The Financial Management Services provider offers supports to the consumer as described in Appendix C.

d) For all health maintenance activities, the consumer 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 participants 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

Self-direction of Health Maintenance Activities and medication set-up is not allowed when the participants attending physician or RN (Registered Nurse) no longer authorizes the participant to self-direct these tasks. Self-direction is not an option when the participant has committed a fraudulent act. Participants residing in a Kansas Department for Aging and Disability (KDADS) licensed assisted living facility, residential health care facility, home plus, or boarding care may not self-direct their services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

a) Consumers 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. Consumers are provided with, at a minimum, the following information about the option to self-direct services:
• the limitation to Direct Support Worker services;
• the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
• related responsibilities (outlined in E-1-a);
• potential liabilities related to the non-fulfillment of responsibilities in self-direction;
• supports provided by the managed care organization (MCO) they have selected;
• the requirements of Direct Support Worker;
• the ability of the consumer to choose not to self-direct services at any time; and
• other situations when the MCO may discontinue the consumer's participation in the self-direct option and recommend agency-directed services.

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

c) Information regarding self-directed services is initially provided by the MCO during the plan of care/service plan process, at which time the Consumer Choice form is completed and signed by the consumer, and the choice is indicated on the consumer's Plan of Care. 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:

The designation of an individual to act on behalf of the participant allows the participant to delegate responsibility for decisions including, but not limited to the following:
• Appointing the direct support worker (s)
• Making financial decision;
• Making health care decision;
• Answering questions during assessment; and

• Signing documents.
The designation is limited to activities necessary to the HCBS/FE case. This designation must also be made either verbally or in writing prior to the start of the initial assessment for HCBS/FE services, or at the time of any subsequent assessments. If this designation is made verbally, it shall be documented in the case log. The participant can change the person authorized to act on their behalf by notifying the MCO at any time.
A participant who is receiving Comprehensive Support is required to have a representative to self-direct support worker can perform the needed services.
A participant who has a guardian or conservator cannot choose to self-direct his or her attendant care, comprehensive support, or sleep cycle support; however a guardian or conservator can make that choice on the ward's behalf.
A guardian, a conservator, a person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a participant cannot choose himself/herself as the paid direct support worker. If the designation of the appointed representative is withdrawn, the individual may become the participant's paid direct support worker after the next annual review or a significant change in the participant's needs occurs prompting a reassessment. (Please reference Field Services Manual (FSM) for additional criteria).
KDADS pulls a representative random sample of all active HCBS/FE waiver participants throughout the state on a quarterly basis, including those that self-direct their care. KDADS Quality Review staff interviews each selected participant to complete a level of care determination, discuss participant satisfaction with services, and identify if there are any health or welfare concerns.
MCOs as part of their on-going monitoring of the participant, ensure the plan of care is appropriate and their health and welfare needs are being met.

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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Sleep Cycle Support - Self-Directed	☑	☐
Financial Management Services	☑	☐
Comprehensive Support - Self-Directed	☑	☐
Attendant Care Services - Self-Directed	☑	☐

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 C1/C3**

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 submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:
• Community Developmental Disability Organization (CDDO) agreement (DD only)
• Secretary of State Certificate of Corporate Good Standing
• W-9 form
• Proof of Liability Insurance
• Proof of Workers Compensation insurance
• Copy of the most recent quarterly operations report or estimate for first quarter operations
• Financial statements (last 3 months bank statements or documentation of line of credit)
• Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). The fully-signed agreement is then submitted by the provider along with the necessary enrollment documents to the State's Fiscal Agent for final review for enrollment to provide FMS. Organizations cannot enroll to provide FMS until an FMS Provider Agreement is fully executed; and must also contract with the KanCare MCO(s) in order to serve KanCare members.

MCO will inform each self-directed participant of these changes in a face –to-face home visit. Each participant will be provided, and will be required to sign, a “Statement of Understanding for Financial Management Services” form. Each participant will have a choice of the available FMS providers.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers will be reimbursed a monthly fee per consumer through the electronic Plans of Care 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 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:

☑ **Assists participant in verifying support worker citizenship status**

- [x] **Collects and processes timesheets of support workers**
- [x] **Processes 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:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [ ] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [ ] **Processes and pays 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:

- [ ] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

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

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments.

Each HCBS provider is to permit KDHE or KDADS, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59).

(b) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by KDADS. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change. KDHE through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities.

(c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency.

(d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members, and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response	☐
Sleep Cycle Support - Self-Directed	☐
Oral Health Services	☐
Home Telehealth	☐
Adult Day Care	☐
Wellness Monitoring	☐
Financial Management Services	☑
Assistive Technology	☐
Attendant Care Services - Provider Directed	☐
Comprehensive Support - Provider Directed	☐
Nursing Evaluation Visit	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Comprehensive Support - Self-Directed	☐
Attendant Care Services - Self-Directed	☐
Medication Reminder	☐

☐ **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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

One of the consumer's opportunities, as well as responsibilities, is the ability to discontinue the self-direct option. At any time, if the consumer 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 attendant coverage for authorized Attendant Care Services and/or Sleep Cycle Support.
- Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the consumer, to allow for the coordination of service provision.

The duties of the consumer's KanCare MCO are to:

- Explore other service options and complete a new Consumer Choice form with the consumer; and
- Advocate for consumers 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 provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The consumer's chosen KanCare MCO or the Kansas Department for Aging and Disability Services may discontinue the consumer's participation in the self-directed option and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the consumer'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 on the Customer Service Worksheet (CSW);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or direct support worker has abused or misused the self-directed care option, such as, but not limited to:
• 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 CSW and/or Plan of Care (POC);
• the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided paid comprehensive support or sleep cycle support beyond the scope of the service definition;
• the participant/representative has submitted signed time sheets for services beyond the scope of the CSW and/or the POC;
• 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 direct support worker 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 registered nurse (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 participants 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 consumer to maintain continuous attendant coverage as outlined and authorized on the consumer's Plan of Care. The MCO, though their care management and monitoring activities, works with the consumer's choice of a non-self-directed agency to assure consumer health and welfare during the transition period and beyond by communicating with both the consumer and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the consumer as to satisfaction with services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	3547	
Year 2	3646	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 3	3744	
Year 4	3843	
Year 5	3942	

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:

Agency with Choice

Participants and their representatives partner with an FMS Provider as their co-employer for the direct support workers who provide waiver services. The agencies perform necessary payroll and human resource functions. Supports are available to assist the participant/representative with employer-related functions.

☐ **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:

Compensation is part of the payment to the FMS Provider.

☑ **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.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**

- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **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 an ADRC to conduct level of care determinations. Decisions made by the ADRC are subject to state fair hearing review, and notice of that right and related process will be provided by the ADRC with their decision on the LOC determination/redetermination.

Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member. In addition, the State will review member grievances/appeals during the initial implementation of the KanCare program on a daily basis to see if there are issues with getting into care, ability to get prescriptions or ability to reach a live person on the phone. The State will report to CMS the number and frequency of these types of complaints/grievances during the initial transition period, and will continue to monitor this issue throughout the KanCare program.

Each member is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet.

KanCare members have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 business days of receipt, and a written response to the grievance will be given to the member within 30 business days (except in cases where it is in the best interest of the member that the resolution timeframe be extended).

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

An appeal can only occur under the following circumstances:
• If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
• You 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: You, your friend, your attorney, or anyone else on your 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 30 calendar days after you have received a Notice of Action.
• The appeal will be resolved within 30 calendar days unless more time is needed. You will be notified of the delay, but your appeal will be resolved in 45 calendar days.

You have other options for a quicker review of your appeal. Call your health plan for more information.

Fair Hearings
A Fair Hearing is a formal meeting where an impartial person (someone you do not know), assigned by the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.
• If you are not satisfied with the decision made on your appeal, you or your representative may ask for a fair hearing. It must be done in writing and mailed or faxed to:

Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

• The letter or fax must be received within 30 days of the date of the appeal decision.

Members have the right to benefits while a hearing is pending, and can request such benefits as part of their fair hearing request. All three MCOs will advise members of their right to a State Fair Hearing. Members do not have to finish their appeal with the MCO before requesting a State Fair Hearing.

Addressing specific additional elements required by CMS:

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

II. All instances when a notice must be made to an individual of an adverse action including: 1) choice of HCBS vs. institutional services, 2) choice of provider or service, and 3) denial, reduction, suspension or termination of service.

The state requires that all MCOs define an "action" pursuant to KanCare RFP Attachment C and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event that their application (choice of HCBS vs. institutional services) is denied, MCOs issue a notice of adverse action under the following circumstances:
• The denial or limited authorization of a requested service, including the type or level of service;
• The reduction, suspension, or termination of a previously authorized service;
• The denial, in whole or in part, of payment for a service;
• The failure to provide services in a timely manner;
• The failure of an Amerigroup 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.

III. How notice of adverse action is made.
Amerigroup: Once the decision to deny a service is made, the Medical Director notifies the Health Care Management Services department of the denial by routing the authorization request to specified queues within Amerigroup's system of record (Facets). An Amerigroup Utilization Management nurse reviews the denial, makes any necessary updates to the authorization and routes it to the designated denial queue in Facets. The Case Specialist assigned to the queue will create the letter in Amerigroup's document repository system (Macess) under the member's account and send to the Amerigroup Document Control Center (DCC) for mailing to both the member and the provider.
Sunflower: Sunflower will issue notice of adverse actions in writing. The notice of action letters utilized by Sunflower will have the prior written approval of KDHE before they are used. Written notification of adverse action may also be supplemented with telephonic and/or face-to-face notifications if necessary.
United: A Notice of Action is provided in writing to the member with a cc: to the provider.

IV. The entity responsible for issuing the notice
Amerigroup: Case Specialists in the Amerigroup Health Care Management Services Department are responsible for issuance of the notice (which includes the Amerigroup Medical Director's signature). These notices are sent from the Case Specialist to Amerigroup's Document Control Center for mailing.
Sunflower: Sunflower State Health Plan is responsible for issuing notifications to its enrolled members. Subcontracted entities who may be delegated appeal may also issue Notice of Action letters to members who are denied or received reduction of services that the delegated entity provides. All of the Sunflower's subcontracted entities will use the previously approved notice of action and grievance/appeal process letters that Sunflower uses.
United: UnitedHealthcare Community Plan will be issuing the notices.

V. The assistance (if any) that is provided to individuals in pursuing a Fair Hearing.
Amerigroup: The Amerigroup Quality Management Department includes Member Advocates that are dedicated to tasks such as helping members file grievances, appeals and Fair Hearings. If a member calls the Amerigroup Member Services line to request assistance with a Fair Hearing, our call center provides a transfer to the Member Advocate who assists the member.
Sunflower: Sunflower's Member Service Representative, Grievance and Appeals Coordinators and Care Managers will all be available to provide personal assistance to members needing support at any stage of the grievance process including Fair

Hearing. They will provide information to members about their rights, how access the Fair Hearing process, provide assistance in completing any required documentation and provide all information relevant to the issue giving rise to the need for a Fair Hearing. In addition, Members will have access to communication assistance such as translation, TTY/TTD availability, interpreter services or alternative formats for member materials.
United: UnitedHealthcare has Member Advocates who can provide general assistance and a Plan Grievance Coordinator who is available to assist members with filing the request and who will prepare the files for submission to the State.

VI. Specify where notices of adverse action and the opportunity to request a Fair Hearing are kept.
Amerigroup: Template Notice of Adverse Action letters are housed in Amerigroup's electronic document repository system (Macess). When individual letters are created, they are saved in the member's individual folder within this system. All these letters include notification of the opportunity to request a Fair Hearing.
Sunflower: Sunflower will maintain records of all notices of adverse action letters issued to members, with the required Fair Hear rights and process language, in our TruCare Medical Management application and in our Customer Relations Management (CRM) application used to track and report events in the grievance process.
United: Notice of Action letters are maintained in corporate letter archives. They are tied to the notification number in our CareOne Medical Management System. They are indexed by State, date of notice, member name. product (i.e. Medicaid) and notification number.

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. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), employs the fiscal agent to operate the consumer complaint and grievance system. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is inluded at Appendix F.1.)

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 participant's chosen KanCare MCO provides information and resources to all consumers and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of 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).

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

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

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

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

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

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

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

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

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

• The method of reporting:

Reports shall be made to the Kansas Department for Children and Families, by calling the Kansas Protection Report Center (a section of DCF), via their 24/7 in-state toll free number: 1-800-922-5330. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911.
Reporting is done immediately on identification of a critical event or incident.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all consumers and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of 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).The state provides for the reporting and investigation of the following major and serious incidents.

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

• The entity that receives reports of each type of critical event or incident: Kansas Department for Children and Families.

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

• The timeframes for conducting an investigation and completing an investigation.
For adults, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of an adult to DCF for review and follow-up. K.S.A. 39-1433 establishes time frames for personal visits with involved adults and due dates for findings for DCF investigations. This statute identifies the following:
1. Twenty-four (24) clock hours if the involved adult's health or welfare is in imminent danger.
2. Three (3) working days if the involved adult has been abused but is not in imminent danger.
3. Five (5) working days if the adult has been neglected or exploited and there is no imminent danger.

• The entity that is responsible for conducting investigations and how investigations are conducted.
Kansas Department for Children and Families is responsible for contacting the involved adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.
1. Interview the involved adult. If the involved adult has a legal guardian or conservator, contact the guardian and/or conservator.
2. Assess the risk of the involved adult.
3. The APS social worker should attempt to obtain a written release from involved adult or their guardian to receive/review relevant records maintained by others.

• The process and timeframes for informing the participant including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.
2540 Notice of Department Finding:
All case decisions/findings shall be staffed with the APS Supervisor/designee and a finding shall be made within (30) working days of receiving the report [K.S.A. 39-1433(a)(3)].

KEESM [12360] allows for joint investigations with KDADS licensed facilities per the option of the DCF Service Center and the facility. Joint investigations require a Memorandum of Agreement between the DCF Service Center and the facility which must be approved by the DCF Central Office APS Attorney. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.
KDADS evaluates and screens incidents in cases of adult care home licensing issues. APS or KDADS conduct investigations in a timely manner depending on type of issue. APS timeframes are: abuse-24 hours, neglect-3 days, exploitation/fiduciary within 7 days. KDADS urveyors must conduct an investigation the same day or next day. Once the investigation is completed, all involved parties receive due process.

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.

The Kansas Department of Children and Families (DCF) Adult Protective Services (APS) and Kansas Department for Aging and Disbility (KDADS) Licensure, Certification, and Evaluation Commission share the oversight and issues as they occur. Participating agencies operate data systems to identify critical event trends and patterns. Opportunities for system improvements and development of strategies progress from the produced trend data with the goal to reduce the future occurrence of critical incidents.

The operating agency has included system enhancements in Appendix H-1, Systems Improvement Work Plan. KDADS Program Managers will work with DCF APS and KDADS LCE to establish 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 Medicaid agency by July 2012.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is

suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education. 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.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

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

As part of its Quality Assurance for HCBS/FE waiver participants, KDADS Program Evaluation staff pull a statistically significant random sample of all active HCBS/FE waiver participants throughout the state on a quarterly basis. KDADS Quality Review staff interview each selected participant to complete a level of care determination, discuss participant satisfaction with services, and identify if there are any health or welfare concerns, including the use of restraints or seclusion.

Kansas Statute (K.S.A.) 39-935 requires the Kansas Department for Aging and Disbility (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. Regulatory requirements for assisted living facilities, residential health care facilities, and homes plus prohibit the admission or retention of any resident whose clinical condition requires the use of physical restraints. KDADS surveyors ensure compliance with adult care home regulatory requirements.

○ **The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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:

As part of its Quality Assurance for HCBS/FE waiver participants, KDADS Program Evaluation staff pull a representative random sample of all active HCBS/FE waiver participants throughout the state on a quarterly basis. KDADS Quality Review staff interview each selected participant to complete a level of care determination, discuss participant satisfaction with services, and identify if there are any health or welfare concerns, including restrictive interventions.

Kansas Statute (K.S.A.) 39-935 requires the Kansas Department for Aging & 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. Regulatory requirements for assisted living facilities, residential health care facilities, and homes plus include the protection and promotion of resident rights. Each resident must have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the adult care home. KDADS surveyors ensure compliance with adult care home regulatory requirements.

○ **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-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.

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 HCBS/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 HCBS/FE waiver participants, KDADS Program Evaluation staff pull a statistically significant random sample of all active HCBS/FE waiver participants throughout the state on a quarterly basis. KDADS Quality Review staff interview each selected participant, including those selected who live in a licensed facility, to complete a level of care determination, discuss participant satisfaction with services, and identify if there are any health or welfare concerns.

Critical events including alleged abuse, neglect, and exploitation are reported to the Kansas Department of Children and Families (DCF) Adult Protective Services (APS) (for in-home complaints), KDADSs Licensure, Certification, and Evaluation (LCE) Commission (for adult care home complaints), and/or law enforcement. Individuals who are considered mandated reporters include case managers, administrators, nurses, and home health workers. Notification can occur by phone or written notification to the appropriate entity.

Whenever a quality reviewer encounters an HCBS/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.

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:

(K.A.R. 26-41-205 and K.A.R. 26-42-205):
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.

Non-medical resident care facilities are not allowed to provide medication management to HCBS/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:

(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:

Assisted Living Facilities, Residential Health Care Facilities, and Homes Plus are required to keep a complete and accurate record of all medications administered by facility staff in each resident's clinical record. Resident clinical records must include, at a minimum, the following information:
• A medical care provider's order for each medication;
• the name of the pharmacy provider of the resident's choice;
• any known medication allergies; and
• the date and the 12-hour or 24-hour clock time any medication is administered to the resident.

A medication error is the preparation or administration of medications or biologicals that is not in accordance with: 1) the prescriber's order (whether given incorrectly or omitting an ordered dosage); 2) manufacturer's specifications regarding the preparation and administration of the medication or

biological; or 3) accepted professional standards and principles that apply to professionals providing services.

The licensed pharmacist or licensed nurse must notify the 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.

Medication errors must be reported to KDADS the state licensing and survey agency, if resident abuse or neglect may have occurred.

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 Disbility (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 Kansas Department of Health and Environment, 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 Managers and case managers are notified at this time so that assistance is available to HCBS/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. The state does not track or trend medication errors as the state does not have the regulatory authority to obtain this information.

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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **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:
Percent of FE waiver participants for whom Quality Review staff observed as having no identifiable health or welfare concerns

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of currently employed ADRC/ MCO that have received training to educate participants on how to identify, protect from, and report abuse, neglect, and exploitation

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number of critical incidents reported by the ADRC / MCOs to the Kansas Department of Children and Families (KDADS) Adult Protective Services (APS) or KDADSs Complaint Hotline that are substantiated versus the total number of critical incidents reported by MCO.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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:
Percent of FE waiver participants who report knowing how to prevent, protect from, and report abuse, neglect, and exploitation

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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 consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education. 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.

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 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.
If errors are identified, the information is submitted to the Kansas Department for Aging and Disablity (KDADS) Program Manager who then follows up with the MCO. Corrective action is taken by the MCO to remedy the problem and the Program Manager is advised. The KDADS Program Manager will log all the remediation activity for tracking and trending purposes. This information will be communicated to the state Medicaid agency when requested and minimally provided on an annual basis.

When KDADS identifies someone who has not attended Uniform Assessment Instrument (UAI) training, the individual is contacted immediately and required to attend the following month's training. The individual is also instructed not to conduct any more assessments until such time as training has been completed. Reimbursement may be recouped for noncompliance.

Steps taken to identify and address non-compliance of assessments and LOC determination:
• Quarterly meetings with appropriate Program and Quality Review staff to determine necessary action;
• Quality Review staff Referral & Response Form to MCO;
• Require MCO) response to KDOA addressing individual problems indicating reason, acceptable remedy, and time frame within 6 working days;
• If no response is received, KDADssends written notification to MCO Director and MCO Supervisor.

If problem continues with same MCO, KDADS may use one or more of the following sanctions, as appropriate:
• Additional KDADS training required
• Corrective Action Plan developed by MCO and agreed upon by KDADS within 30 days
• Monetary penalty
• Possible suspension or termination of MCO provider agreement

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.
WORK PLAN:

Operating agency will require data entry of incident reports and outcomes in the Kansas Aging Management Information System (KAMIS) by March 2010

Operating agency will add question to Quality Review Protocol to monitor performance measures for health and welfare by July 2010

Operating agency will work with DCF APS and KDADS LCE to establish a formal process including reports generated for trending, the frequency of those reports, as well as how this information is communicated to KDHE, the single state Medicaid agency, by July 2012. Until the formal process is developed and implemented, KDADS will provide on-going information during the monthly long-term care meetings.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Kansas Health Policy Authority (KHPA), the single state Medicaid agency, and the Kansas Department on Aging (KDOA) collaborate in developing state operating agency priorities to meet established waiver assurances and minimum standards of service. Through KDOA's Quality Review process, a statistically significant random sample of waiver participants are interviewed and data collected for meaningful consumer feedback on the HCBS/FE program. The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDOA Program Managers regularly communicate with Targeted Case Managers and FE service providers, thereby ensuring continual guidance on the FE waiver service delivery system.

KDOA Quality Review staff collects data based on participant interviews and case file reviews. KDOA Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and Case Management Entity (CME) level to initiate the HCBS/FE Quality Improvement process. This information is provided quarterly and annually to KDOA Management and the KHPA Long-Term Care Committee. In addition, each CME receives quarterly and annually-trended results, which identifies CME-specific performance levels related to established policy and performance standards as well as statewide averages.

In addition to the Quarterly Quality Review Report, KDOA's Program Evaluation compiles monthly reports on the Level of Care scores to verify participant functional eligibility. Monthly reports are also generated to verify participant age and expired assessment dates. Operating agency program staff generate a quarterly report to verify assessor qualifications. These reports are provided to the operating agency program managers.

KDOA's process allows for review of HCBS/FE waiver results for policy and procedure development as well as system change initiatives.

KDOA WORKPLAN:

KDOA will convene an internal HCBS/FE Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS/FE Waiver Quality Review Reports and identify areas for improvement beginning February 2010.

KDOA will establish an HCBS/FE Quality Improvement Steering Committee, to include HCBS/FE waiver participants, Quality Review staff, and representatives from CMEs and service providers. Beginning in April 2011, this committee will meet bi-annually to evaluate the HCBS/FE waiver service delivery system, recommend systems improvement, and establish priorities.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: Bi-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.

The Kansas Department on Aging (KDOA) and Kansas Health Policy Authority (KHPA) 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 FE waiver participants are monitored and analyzed through KDOA's Quality Review process. Additional questions may be added to the HCBS/FE Customer Interview Protocol to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS/FE Case File Quality Review Protocol. 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, the KDOA 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 CME is sufficient, or if a system change is required.
If a system change is required, KDOA convenes a workgroup to draft the new or revised policy. If the change impacts the Medicaid Management Information System (MMIS), a concept paper is developed and the new policy is presented to KHPA Management for approval. The draft policy is distributed to KHPA, CMEs, and advocacy organizations for a 30-day comment period. At the end of the comment period, KDOA staff take each comment received under consideration and write a final policy, which must be reviewed and approved by the Secretary of KDOA. The final policy is then distributed to stakeholders via KDOA's Provider Website and, if needed, Provider Manuals on the Kansas Medical Assistance Program (KMAP) website are updated and providers notified of the change.
The Kansas Aging Management Information System (KAMIS) is the official electronic repository of data about KDOA's customers and the services they receive. This customer-based data is used by KDOA and the CMEs to coordinate activities and manage Aging programs. System changes are made to KAMIS to enhance the availability of information on participants and manage program budgets and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDOA Program Managers, and Quality Review staff, and approved and prioritized by KDOA management. Effectiveness of the system design change is monitored by KDOA's Program Managers, working in concert with KDOA's Quality Review and Program Evaluation staff.
KHPA contracts with Electronic Data Systems (EDS) to manage the Medicaid Management Information System (MMIS). Improvements to this system require KHPA approval of the concept and prioritization of the change. KDOA staff work with KHPA and EDS staff to generate recommended systems changes, which are then monitored and analyzed by EDS and KDOA to ensure the system change operates as intended and meets the desired performance outcome.

Please refer to the Work Plan for additional information on the operating agency's plans for development of a Quality Improvement (QI) Steering Committee.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDOA will use to identify and implement Quality Improvements and periodically evaluate the state's Quality Improvement Strategy:

WORK PLAN:

Operating agency will convene an internal HCBS/FE Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS/FE Waiver Quality Review Reports and identify areas for improvement beginning February 2010.

Operating agency will establish an HCBS/FE Quality Improvement Steering Committee, to include HCBS/FE waiver participants, Quality Review staff, and representatives from CMEs and service providers. Beginning in April 2011, this committee will meet bi-annually to evaluate the HCBS/FE waiver service delivery system, recommend systems improvement, and establish priorities.

Operating agency will work with SRS APS and KDOA LCE to establish 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 KHPA, the single state Medicaid agency, by July 2012

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial

audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, inculding:
a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviewes/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficience, and coordination of care, and the cost of care.

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 KanCare Interagency Monitoring Team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

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 function under this contract;
(2) Liaison with the State in all matters regarding program integrity;
(3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
(4) Liaison with Kansas' MFCU;
(5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the 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: Financial Accountability**
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. **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:
Percent of FE provider claims paid in accordance with the state's approved reimbursement methodology

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

☑ **Other** Specify: KanCare MCOs contracting with Kansas	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state established a KanCare Interagency Coordination and Contract Monitoring (KICCM) to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the Interagency Monitoring Team that engages program management, contract management and financial management staff of both KDHE and KDADS.

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

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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.

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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECES, the State's eligibility system. The state also is requiring the MCOs to utilize the State's contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the consumer's 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.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

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. *Select one:*

- ○ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

When establishing reimbursement rates as described in Appendix I-2,a, no expenses associated with room and board are considered.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10353.22	1980.00	12333.22	25403.00	2116.00	27519.00	15185.78
2	10993.46	2085.00	13078.46	27707.00	2227.00	29934.00	16855.54
3	10985.19	2085.00	13070.19	28675.00	2227.00	30902.00	17831.81
4	8611.50	3711.00	12322.50	41113.00	2638.00	43751.00	31428.50
5	8707.36	3735.00	12442.36	41462.00	2660.00	44122.00	31679.64

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	7882	7882
Year 2	8101	8101
Year 3	8321	8321
Year 4	8084	8084
Year 5	8084	8084

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 was calculated by using the total days of waiver coverage for SFY2010 (7/1/2009 - 6/30/2010) : 2,465,863, divided by the unduplicated number served: 8,187, or 301 ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was estimated by utilizing data from the Kansas MMIS system and reflects the average HCBS waiver service cost and utilization for FE waiver participants for the state fiscal years July 2007 through June 2010. This average expenditure was projected to Year 4 of the waiver, which is then projected to Year 5 of the waiver at an average annual trend of 0.75%.

The FMS cost is determined by the number of Attendant Care Services - Self-Directed consumers at $115.00 per month with an Avg. Units/User similar to Personal Emergency Response - Ongoing Service due to the unit basis of 1 month.

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 estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for FE waiver participants for the state fiscal years July 2007 through June 2010. This average expenditure was projected to Year 4 of the waiver, which is then projected to Year 5 of the waiver at an average annual trend of 0.75%.

Factor D' does not include the cost of Medicare Part D Prescribed Drugs. This is not a Medicaid cost and is not paid through the MMIS system.

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 was estimated by utilizing data from the Kansas MMIS system and reflects the average nursing facility cost and utilization for nursing facility members for the state fiscal years July 2007 through June 2010. This average expenditure was projected to Year 4 of the waiver, which is then projected to Year 5 of the waiver at an average annual trend of 0.85%.

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' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for nursing facility members for the state fiscal years July 2007 through June 2010. This average expenditure was projected to Year 4 of the waiver, which is then projected to Year 5 at an average annual trend of 0.85%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Financial Management Services	
Adult Day Care	
Assistive Technology	
Attendant Care Services - Provider Directed	
Attendant Care Services - Self-Directed	
Comprehensive Support - Provider Directed	
Comprehensive Support - Self-Directed	
Home Telehealth	

Waiver Services	
Medication Reminder	
Nursing Evaluation Visit	
Oral Health Services	
Personal Emergency Response	
Sleep Cycle Support - Self-Directed	
Wellness Monitoring	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							0.00
Financial Management Services		1 month	0	0.00	115.00	**0.00**	
Adult Day Care Total:							806329.30
Adult Day Care		1-5 hours	158	245.00	20.83	**806329.30**	
Assistive Technology Total:							15793.75
Assistive Technology		1 purchase	19	1.00	831.25	**15793.75**	
Attendant Care Services - Provider Directed Total:							42074364.00
Attendant Care Services - Provider Directed - Level I		15 minutes	1576	750.00	3.21	**3794220.00**	
Attendant Care Services - Provider Directed - Level II		15 minutes	3862	2800.00	3.54	**38280144.00**	
Attendant Care Services - Provider Directed Level III		15 minutes	0	0.00	4.12	**0.00**	
Attendant Care Services - Self-Directed Total:							37367645.00
Attendant Care Services - Self-Directed		15 minutes	3547	3500.00	3.01	**37367645.00**	
Comprehensive Support - Provider Directed Total:							20865.00
					GRAND TOTAL:		**81604072.38**
					Total Estimated Unduplicated Participants:		**7882**
					Factor D (Divide total by number of participants):		**10353.22**
					Average Length of Stay on the Waiver:		301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Comprehensive Support - Provider Directed		15 minutes	5	1300.00	3.21	**20865.00**	
Comprehensive Support - Self-Directed Total:							46053.00
Comprehensive Support - Self-Directed		15 minutes	9	1700.00	3.01	**46053.00**	
Home Telehealth Total:							0.00
Home Telehealth - Installation/training		1 install	0	0.00	70.00	**0.00**	
Home Telehealth - Ongoing services		1 day	0	0.00	5.00	**0.00**	
Medication Reminder Total:							604.40
Medication Reminder		1 month	5	8.00	15.11	**604.40**	
Nursing Evaluation Visit Total:							2954.60
Nursing Evaluation Visit		1 face to face per prc	79	1.00	37.40	**2954.60**	
Oral Health Services Total:							43225.00
Oral Health Services		1 unit	35	1300.00	0.95	**43225.00**	
Personal Emergency Response Total:							899794.73
Personal Emergency Response - Ongoing services		1 month	3783	9.00	25.19	**857643.93**	
Personal Emergency Response - One time installation fee		1 install	631	1.25	53.44	**42150.80**	
Sleep Cycle Support - Self-Directed Total:							55218.80
Sleep Cycle Support - Self-Directed		6 to 12 hours	14	185.00	21.32	**55218.80**	
Wellness Monitoring Total:							271224.80
Wellness Monitoring		1 face to face every 5	1813	4.00	37.40	**271224.80**	
					GRAND TOTAL:		**81604072.38**
					Total Estimated Unduplicated Participants:		**7882**
					Factor D (Divide total by number of participants):		**10353.22**
					Average Length of Stay on the Waiver:		301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							1257760.62
Financial Management Services		1 month	3646	9.00	38.33	**1257760.62**	
Adult Day Care Total:							870401.70
Adult Day Care		1-5 hours	162	245.00	21.93	**870401.70**	
Assistive Technology Total:							16625.00
Assistive Technology		1 purchase	19	1.00	875.00	**16625.00**	
Attendant Care Services - Provider Directed Total:							46840739.00
Attendant Care Services - Provider Directed - Level I		15 minutes	1620	750.00	3.38	**4106700.00**	
Attendant Care Services - Provider Directed - Level II		15 minutes	3820	2800.00	3.73	**39896080.00**	
Attendant Care Services - Provider Directed Level III		15 minutes	1475	467.00	4.12	**2837959.00**	
Attendant Care Services - Self-Directed Total:							38538220.00
Attendant Care Services - Self-Directed		15 minues	3646	3500.00	3.02	**38538220.00**	
Comprehensive Support - Provider Directed Total:							30758.00
Comprehensive Support - Provider Directed		15 minutes	7	1300.00	3.38	**30758.00**	
Comprehensive Support - Self-Directed Total:							61608.00
Comprehensive Support - Self-Directed		15 minutes	12	1700.00	3.02	**61608.00**	
Home Telehealth Total:							29010.00
Home Telehealth - Installation/training		1 install	60	1.25	70.00	**5250.00**	
Home Telehealth - Ongoing services		1 day	110	36.00	6.00	**23760.00**	

GRAND TOTAL:	**89058037.80**
Total Estimated Unduplicated Participants:	**8101**
Factor D (Divide total by number of participants):	**10993.46**
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder Total:							636.40
Medication Reminder		1 month	5	8.00	15.91	**636.40**	
Nursing Evaluation Visit Total:							6377.94
Nursing Evaluation Visit		1 face to face per prc	162	1.00	39.37	**6377.94**	
Oral Health Services Total:							63700.00
Oral Health Services		1 unit	49	1300.00	1.00	**63700.00**	
Personal Emergency Response Total:							973789.02
Personal Emergency Response - Ongoing services		1 month	3889	9.00	26.52	**928226.52**	
Personal Emergency Response - One time installation fee		1 install	648	1.25	56.25	**45562.50**	
Sleep Cycle Support - Self-Directed Total:							62271.00
Sleep Cycle Support - Self-Directed		6 to 12 hours	15	185.00	22.44	**62271.00**	
Wellness Monitoring Total:							306141.12
Wellness Monitoring		1 face to face every (	1944	4.00	39.37	**306141.12**	
					GRAND TOTAL:		**89058037.80**
					Total Estimated Unduplicated Participants:		**8101**
					Factor D (Divide total by number of participants):		**10993.46**
					Average Length of Stay on the Waiver:		297

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							3875040.00
					GRAND TOTAL:		**91407737.86**
					Total Estimated Unduplicated Participants:		**8321**
					Factor D (Divide total by number of participants):		**10985.19**
					Average Length of Stay on the Waiver:		299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services		1 month	3744	9.00	115.00	**3875040.00**	
Adult Day Care Total:							891893.10
Adult Day Care		1-5 hours	166	245.00	21.93	**891893.10**	
Assistive Technology Total:							17500.00
Assistive Technology		1 purchase	20	1.00	875.00	**17500.00**	
Attendant Care Services - Provider Directed Total:							49113468.00
Attendant Care Services - Provider Directed - Level I		15 minutes	1664	750.00	3.38	**4218240.00**	
Attendant Care Services - Provider Directed - Level II		15 minutes	1957	2800.00	3.73	**20438908.00**	
Attendant Care Services - Provider Directed Level III		15 minutes	2120	2800.00	4.12	**24456320.00**	
Attendant Care Services - Self-Directed Total:							35511840.00
Attendant Care Services - Self-Directed		15 minutes	3744	3500.00	2.71	**35511840.00**	
Comprehensive Support - Provider Directed Total:							30758.00
Comprehensive Support - Provider Directed		15 minutes	7	1300.00	3.38	**30758.00**	
Comprehensive Support - Self-Directed Total:							55284.00
Comprehensive Support - Self-Directed		15 minutes	12	1700.00	2.71	**55284.00**	
Home Telehealth Total:							434237.50
Home Telehealth - Installation/training		1 install	173	1.25	70.00	**15137.50**	
Home Telehealth - Ongoing services		1 day	254	275.00	6.00	**419100.00**	
Medication Reminder Total:							636.40
Medication Reminder		1 month	5	8.00	15.91	**636.40**	
Nursing Evaluation Visit Total:							6535.42
Nursing Evaluation Visit		1 face to face per prc	166	1.00	39.37	**6535.42**	

GRAND TOTAL:	**91407737.86**
Total Estimated Unduplicated Participants:	**8321**
Factor D (Divide total by number of participants):	**10985.19**
Average Length of Stay on the Waiver:	299

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Oral Health Services Total:							80600.00
Oral Health Services		1 unit	62	1300.00	1.00	**80600.00**	
Personal Emergency Response Total:							1000116.05
Personal Emergency Response - Ongoing services		1 month	3994	9.00	26.52	**953287.92**	
Personal Emergency Response - One time installation fee		1 install	666	1.25	56.25	**46828.12**	
Sleep Cycle Support - Self-Directed Total:							62271.00
Sleep Cycle Support - Self-Directed		6 to 12 hours	15	185.00	22.44	**62271.00**	
Wellness Monitoring Total:							327558.40
Wellness Monitoring		1 face to face every (	2080	4.00	39.37	**327558.40**	
					GRAND TOTAL:		**91407737.86**
					Total Estimated Unduplicated Participants:		**8321**
					Factor D (Divide total by number of participants):		**10985.19**
					Average Length of Stay on the Waiver:		299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							3466576.10
Financial Management Services	✓	1 month	3497	8.62	115.00	**3466576.10**	
Adult Day Care Total:							630999.78
Adult Day Care	✓	1-5 hours	84	342.54	21.93	**630999.78**	
Assistive Technology Total:							60408.48
					GRAND TOTAL:		**69615342.04**
					Total Estimated Unduplicated Participants:		**8084**
					Factor D (Divide total by number of participants):		**8611.50**
					Average Length of Stay on the Waiver:		301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	✓	1 purchase	24	1.00	2517.02	**60408.48**	
Attendant Care Services - Provider Directed Total:							34089692.37
Attendant Care Services - Provider Directed - Level I	✓	15 minutes	1006	836.27	3.38	**2843552.16**	
Attendant Care Services - Provider Directed - Level II	✓	15 minutes	1502	1452.50	3.73	**8137573.15**	
Attendant Care Services - Provider Directed Level III	✓	15 minutes	2161	2595.50	4.12	**23108567.06**	
Attendant Care Services - Self-Directed Total:							29294331.93
Attendant Care Services - Self-Directed	✓	15 minutes	3497	3091.14	2.71	**29294331.93**	
Comprehensive Support - Provider Directed Total:							16465.70
Comprehensive Support - Provider Directed	✓	15 minutes	7	695.93	3.38	**16465.70**	
Comprehensive Support - Self-Directed Total:							44014.19
Comprehensive Support - Self-Directed	✓	15 minutes	7	2320.20	2.71	**44014.19**	
Home Telehealth Total:							763992.50
Home Telehealth - Installation/training	✓	1 install	271	1.25	70.00	**23712.50**	
Home Telehealth - Ongoing services	✓	1 day	398	310.00	6.00	**740280.00**	
Medication Reminder Total:							1890.11
Medication Reminder	✓	1 month	66	1.80	15.91	**1890.11**	
Nursing Evaluation Visit Total:							4802.35
Nursing Evaluation Visit	✓	1 face to face per prc	107	1.14	39.37	**4802.35**	
Oral Health Services Total:							103251.81
Oral Health Services	✓	1 unit	406	3.69	68.92	**103251.81**	
Personal Emergency Response Total:							885165.43
Personal Emergency Response - Ongoing services	✓	1 month	3662	8.62	26.52	**837141.99**	

GRAND TOTAL:	**69615342.04**
Total Estimated Unduplicated Participants:	**8084**
Factor D (Divide total by number of participants):	**8611.50**
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response - One time installation fee	✓	1 install	683	1.25	56.25	**48023.44**	
Sleep Cycle Support - Self-Directed Total:							28647.80
Sleep Cycle Support - Self-Directed	✓	6 to 12 hours	8	159.58	22.44	**28647.80**	
Wellness Monitoring Total:							225103.49
Wellness Monitoring	✓	1 face to face every (	1798	3.18	39.37	**225103.49**	
					GRAND TOTAL:		**69615342.04**
					Total Estimated Unduplicated Participants:		**8084**
					Factor D (Divide total by number of participants):		**8611.50**
					Average Length of Stay on the Waiver:		301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. 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. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							3486683.85
Financial Management Services	✓	1 month	3497	8.67	115.00	**3486683.85**	
Adult Day Care Total:							635070.87
Adult Day Care	✓	1-5 hours	84	344.75	21.93	**635070.87**	
Assistive Technology Total:							60861.84
Assistive Technology	✓	1 purchase	24	1.00	2535.91	**60861.84**	
Attendant Care Services - Provider Directed Total:							34309913.63
Attendant Care Services - Provider Directed - Level I	✓	15 minutes	1006	841.67	3.38	**2861913.67**	
					GRAND TOTAL:		**70390290.35**
					Total Estimated Unduplicated Participants:		**8084**
					Factor D (Divide total by number of participants):		**8707.36**
					Average Length of Stay on the Waiver:		301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Services - Provider Directed - Level II	✓	15 minutes	1502	1461.88	3.73	**8190124.22**	
Attendant Care Services - Provider Directed Level III	✓	15 minutes	2161	2612.27	4.12	**23257875.74**	
Attendant Care Services - Self-Directed Total:							29482921.64
Attendant Care Services - Self-Directed	✓	15 minutes	3497	3111.04	2.71	**29482921.64**	
Comprehensive Support - Provider Directed Total:							16589.21
Comprehensive Support - Provider Directed	✓	15 minutes	7	701.15	3.38	**16589.21**	
Comprehensive Support - Self-Directed Total:							44344.27
Comprehensive Support - Self-Directed	✓	15 minutes	7	2337.60	2.71	**44344.27**	
Home Telehealth Total:							1095691.50
Home Telehealth - Installation/training	✓	1 install	369	1.25	70.00	**32287.50**	
Home Telehealth - Ongoing services	✓	1 day	542	327.00	6.00	**1063404.00**	
Medication Reminder Total:							1900.61
Medication Reminder	✓	1 month	66	1.81	15.91	**1900.61**	
Nursing Evaluation Visit Total:							4844.48
Nursing Evaluation Visit	✓	1 face to face per prc	107	1.15	39.37	**4844.48**	
Oral Health Services Total:							104091.25
Oral Health Services	✓	1 unit	406	3.72	68.92	**104091.25**	
Personal Emergency Response Total:							891286.86
Personal Emergency Response - Ongoing services	✓	1 month	3662	8.67	26.52	**841997.80**	
Personal Emergency Response - One time installation fee	✓	1 install	701	1.25	56.25	**49289.06**	
Sleep Cycle Support - Self-Directed Total:							28863.23

GRAND TOTAL:	**70390290.35**
Total Estimated Unduplicated Participants:	**8084**
Factor D (Divide total by number of participants):	**8707.36**
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Sleep Cycle Support - Self-Directed	✓	6 to 12 hours	8	160.78	22.44	**28863.23**	
Wellness Monitoring Total:							227227.10
Wellness Monitoring	✓	1 face to face every (	1798	3.21	39.37	**227227.10**	
					GRAND TOTAL:		**70390290.35**
					Total Estimated Unduplicated Participants:		**8084**
					Factor D (Divide total by number of participants):		**8707.36**
					Average Length of Stay on the Waiver:		301