Kansas Department of Aging and Disability Services

Proposed Changes to HCBS Programs
Posted for Public Comment

Public Comment Period: **Posted:** November 10, 2014 **Ends:** December 20, 2014

KDADS 503 S. Kansas Ave, Topeka, KS 66603 * www.kdads.ks.gov * 785-296-4986 * HCBS-KS@kdads.ks.gov

The proposed changes are open to public comment and feedback effective 11/10/14 through 12/20/14. Public comments/ inputs regarding the proposed changes will be reviewed by KDADS leadership and will be amended if necessary prior to submission to CMS for approval. The final proposal will be posted to the KDADS website at www.kdads.ks.gov .

This is a summary of the proposed changes in the HCBS renewals for the following programs:

- Frail Elderly
- Intellectual/Developmental Disability
- Physical Disability
- Traumatic Brain Injury

The **draft** renewals, which include the Transition Plan for Home and Community-Based Services (HCBS) Settings and proposed changes for each HCBS Program's renewal are available online at www.KDADS.ks.gov for public comment until December 20, 2014. Only the areas of proposed changes identified in the summary document are available for public comment.

You may access the documents three ways:

- **Online:** www.KDADS.ks.gov – on the home page
- **In Person:** At your local Community Developmental Disability Organization (CDDO), Aging and Disability Resource Center (ADRC) or Center for Independent Living (CIL).
- **By Email:** HCBS-KS@kdads.ks.gov, *Subject Line:* HCBS Renewal Information Request

Comments can be submitted to KDADS **during the comment period** the following ways:

- **In Person:** November 12th -14th from 10-12 and 2-4 in Wichita, Hays, and Lawrence
- **By Phone:** 785-296-4986 or 785-296-3473

  On the following dates call: 1-866-620-7326, code 4283583031
  November 17th from 11 am to 12 pm and 5:30 pm to 6:30 pm
  December 4th from 12:00 pm to 1:00 pm

- **By Email:** HCBS-KS@kdads.ks.gov – **Subject:** HCBS Renewals Public Comments
- **By Mail:** KDADS, Attn: HCBS Programs, 503 S. Kansas Ave, Topeka, KS 66603.
- **By Fax:** 785-296-0256, Attn: HCBS Programs

After the public information sessions, an online survey will be available for individuals, providers, and stakeholders to submit comments and questions to KDADS. A summary of responses will available online after the public comment period has ended for the renewals or any changes to them, and the summary of responses will be provided to CMS as part of the renewal submission. Throughout the public comment period, KDADS will continue to be available for presentations, public meetings and question and answer sessions to various state agencies, contracted entities, and community providers related to the HCBS renewals and Final Rule.

The following proposed changes are open from public comment. Please submit suggestions, changes, questions, comments and concerns to the State by December 20, 2014.

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KDAD is proposing the following changes to all HCBS programs.

- **Definition of Personal Care Services was standardized across the programs**

   a. Personal Care Service (PCS) is not available as a State plan service but is available for members on HCBS programs. The functions of a PCS includes but is not limited to assisting with activities of daily living ADLs (bathing, grooming, toileting, transferring), health maintenance activities (including but not limited to extension of therapies), feeding, mobility and exercises, socialization and recreation activities. The PCS supports the participant in accessing medical services and normal daily activities by accompanying the participant to accomplish tasks as listed within the scope of service in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.

   - PCS can be provided and reimbursed based on the assessed needs of the participant as identified on the participant's Plan of Care (POC).

   - This service provides necessary assistance for individuals both in their home and community. Home is where the individual make his/her residence, and must not be defined as institutional in nature and must comply with the HCBS final rule setting. PCS may be provided in a setting where the individual lives with a family. A family is defined as any person immediately related to the participant, such as parents/ legal guardian, spouse; or when the participant lives with other persons capable of providing the care as part of the informal support system.

   b. **Informal Supports/Capable Person Policy.**

   It is the expectation that program participants who need assistance with activities for daily living (ADL) or independent activities of daily living (IADL) tasks to receive those supports from informal supports, which may include relatives, friends, or community supports. These informal supports should not be replaced by formal supports for the purpose of accessing services. and who live with persons capable of performing these tasks, should rely on these informal/natural supports for this assistance unless there are extenuating or specific circumstances that have been documented in the plans of care.

   In accordance with this expectation, a member who has access to the informal supports of a capable person will not be allotted PCS for instrumental activities of daily living on their plan of care, in accordance with the capable person policy. Specifically, no time will be allowed on the Plan of Care for PCS to complete activities such as lawn care, snow removal, shopping, ordinary housekeeping or laundry or meal preparation as these tasks can be completed in conjunction with activities done by the capable person. PCS may be reimbursed for preparation of a specialized diet that is medically prescribed and requiring specialized preparation or designed specifically for the participant's dietary needs as assessed by the MCO and identified on the integrated service plan/plan of care.

   - General Exceptions: If a capable person refuses to or is unable to provide informal support for instrumental activities for daily living, the refusal or inability to perform the task(s) must be documented in a writing signed by the Capable Person. The capable person will not be reimbursed to perform these services, but the individual may have the services allocated

on their plan of care and provided by an agency-directed service or through a new PCS provider, who is not a capable person for the individual.

- The service must occur in the home or community location meeting the setting requirements as defined in the "HCBS Setting Final Rule".
  - Service provided in a home school setting must not be educational in purpose.
  - Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with Intellectual Disability (ICF-ID), or institution for mental disease are not covered.

c. PCS will be coordinated by the KanCare MCO Care Manager and arranged for, and purchased under the individual or legally responsible party's written authority, and paid through an enrolled fiscal management service agent consistent with and not exceeding the individuals Plan of Care.
  - Individual or legally responsible individual with the authority to direct services who may at some point determine that they no longer want to participant-direct his/her service will have the opportunity to receive the previously approved program service, without penalty.
  - A PCS may not perform any duties not delegated by the participant or participant's representative with the authority to direct services or duties as approved by the participant's physician and must be identified as a necessary task in the plans of care. PCS may not be provided by the parent or legal guardian for the minor program Participant.
  - The cost associated with the provider traveling to deliver this service is included in the rate paid to the provider. Non-emergency Medical Transportation (NEMT) service is a state plan service and can be accessed through the participant's chosen KanCare MCO.
  - Participants under the age of 21 who are eligible to receive EPSDT services may access those services through the Medicaid state plan. PCS targeted for this population are non-duplicative of services provided under EPSDT.

- **Added language about change of functional eligibility assessment tool**

a. Kansas has contracted with Kansas University (KU) to evaluate the current assessment instrument in comparison to other States to identify an assessment instrument with demonstrated reliability and validity. The purpose of this contract is to develop a standardized eligibility assessment to assess level of care eligibility for all HCBS populations served by Kansas programs. This study seeks input from assessors, stakeholders and entities who work with HCBS populations as subject matter experts, in order to provide input on assessment instruments recommended for consideration. The contractor has concluded their study and has submitted recommendations to Kansas for review and approval.

b. A draft of the standardized eligibility instrument has been developed based upon input collected the assessors, stakeholders, and entities who work with the HCBS populations. The standardized eligibility instrument draft will be tested and administered with the current functional eligibility instrument during a four to six month time period. Following the conclusion of the testing, the standardized eligibility instrument will be refined and adjusted based on data collected during the field testing until a final version of the eligibility

instrument is developed. Input from assessor, stakeholder, and entities who work with HCBS populations will continued to be gathered throughout the process and planning webinars about the eligibility instrument will be provided for additional providers and the public. Once the eligibility instrument has been finalized, an in-depth training on the instrument will be provided to assessors.

c. Following final decision of a statewide eligibility assessment instrument, Kansas will develop a work plan to implement a phase in assessment process to include dual assessment using the current assessment tool and the new statewide assessment instrument in order to evaluate outcome. Kansas anticipates a phase-in implementation of the new statewide assessment instrument to begin by 01/1/15. In order to comply with CMS requirement, Kansas will be submitting an amendment for all HCBS programs to include the new statewide assessment instrument for CMS review and approval 90 days prior to planned implementation date.

- **Proposed Change in Service Definition for FMS**

Kansas is promoting true choice by making options available to the participant or responsible party by entering into an employment support with the Financial Management Services (FMS) provider and to work collaboratively with the FMS to ensure the receipt of quality, needed support services from direct support workers. The participant retains the sole responsibility as the common law employer. FMS service will be provided through a third party entity. For detailed information about the language related to FMS model, please review the FMS Proposed Changes document on the KDADS website.

a. The MCO will inform individuals who are seeking or receiving participant-directed services of their rights and responsibilities as employers who are self-directing their care funded through Medicaid. The MCO will be responsible for informing the participant that agency-directed services can be made at any time if the participant no longer desires to participant-direct his/her service(s). The K-PASS, the participant-direction tool kit, is available to all participants through the KDADS website.

b. This service does not duplicate other waiver services including case management. Where the possibility of duplicate provision of services exists, the participant plan of care shall clearly delineate responsibilities for the performance of activities.

c. The FMS provider will provide information related to employer responsibilities, including potential liabilities associated with participant direction. FMS support will be provided within the scope of the Employer Authority model. FMS is available:

- To participants who reside in their own private residences or the private home of a family member and have chosen to participant-direct their services.
- To assists the participant or participant's representative by providing two distinct types of tasks:
  a. Administrative Tasks (such as filing payroll tasks and paying the worker)
  b. Information and Assistance (I & A) Tasks (such as background checks and information on arranging services and managing workers).

d. The FMS provider is also responsible for informing participant that he/she must exercise responsibility for making the choice to participant-direct his/her attendant care services, understand the impact of the choices made, and assume responsibility for the results of any

decisions and choices that was made. The FMS is responsible for clearly communicating verbally and in writing the participant's responsibilities relating his/her role as an employer of a direct service worker, the information and assistance provided, at a minimum must include, but not limited to hiring, firing, training, managing, scheduling, and monitoring hours of the direct support worker.

e. **FMS Provider Requirements**
   - Enrolled FMS providers will furnish Financial Management Services according to Kansas model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.
   - The FMS provider must submit a signed Provider Agreement and all required documents to the State Operating Agency, KDADS, prior to enrollment to provide the service. KDADS will review the documents as part of a readiness review prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

f. **Payment for FMS**
   - FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

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

- **Proposed Requirement of Background Checks for All Services and Assessors**
  a. All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, Nurse Aid Registry, and Motor Vehicle screen.

- **Proposed Addition of Prohibited Offenses Language to All Services**
  a. Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

- **Updated language from consumer/individual/person/beneficiary to participant**

- **Proposed Language Applicable to All HCBS Services For the Purpose of Mitigating Conflict of Between Guardian and Consumer.**

CMS has requested Kansas to provide specific information on how it mitigates potential conflict of interest and ensures that the guardian being paid as the provider and developing the plan of care with MCOs is in the best interest of the consumer in compliance with 42 CFR §441.301(b)(1)). Kansas is committed to supporting families and individuals who are aging and disabled, so that they can be independent and included in their home and community. To comply with the HCBS Final Rule, the following assurances are proposed to mitigate potential conflicts between the role of guardian, legal guardian, durable power of attorney, and other legally responsible individuals directing the plan of care and the guardian as a paid care giver of services for the participant. This is proposed language, open for public comment, based on Oregon's model.

a. The home and community based services final rule prohibits providers of 1915(c) waiver services and those with an interest in or employed by a provider of HCBS services from developing the person-centered services. Since the individuals or entities responsible for person-centered plan development must be independent of the HCBS provider, a legal guardian, durable power of attorney, and other legally responsible individuals who receive payment for providing HCBS may not be responsible for development of the person-centered plan.

b. Court-appointed legal guardians of adults receiving Medicaid-funded home and community based services must comply with state law regarding guardianship and reporting of potential conflicts of interest to the court (K.S.A. 59-3068). If a conflict of interest exists, legal guardians of adults receiving Medicaid-funded home and community based services must designate a representative to direct the services of an individual the guardian provides supports to and represents. Annually, the legal guardian will provide the State or designee with a file-stamped copy of the special or annual report in which the conflict of interest is disclosed.

c. Care coordinators and financial management service providers who identify situations in which a conflict of interest exists must provide information to the individual and the legal guardian to address the conflict. This action will allow legal guardians to address conflict of interest, while retaining the right to be a paid care provider.

d. An exception to the criteria may granted by the State when a participant/ guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence; or

e. CMS provides an exception to this rule if there is only one willing and qualified provider in a geographical area who provides HCBS, case management, and develops the person-centered plan. However, in these situations, the state must develop conflict of interest protections to separate provider functions and obtain approval from CMS. In additional, individual recipients of services must have an alternate dispute resolution process available.

- **Proposed Language Applicable to All HCBS Services For the Purpose of Mitigating Other Conflicts of Interests.**

"Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including

separation of entity and provider functions within provider entities, which must be approved." (42 CFR §441.301(b)(1))

In general, an HCBS provider, its employees and related entities, cannot provide service planning or case management for the beneficiary. HCBS state-plan services require conflict of interest standards and safeguards. At a minimum, assessor, case manager, and agent determining eligibility cannot be:

1. Related by blood or marriage to the consumer;
2. Related to any paid service provider for the consumer;
3. Financially responsible for the consumer;
4. Empowered to make the consumer's financial or health related decisions; or
5. Hold a financial interest in any entity paid to provide "care" for the consumer.

If the only willing and qualified provider in a rural area provides case management, and develop the person-centered service plan, also provides direct services, the state will ensure administrative firewalls are present. The State will ensure the following:

- The agency does not case manage the clients to whom it provides services.
- The governing structure is transparent with stakeholder involvement.
- Staff should not be rewarded or penalized based on care planning results.
- Case management functions and direct service provision are separated
- Agency should have a conflict of interest policy available for consumers
- Agency should have and maintain a participant complaint system and track and monitor complaints that are reported to the State

The State will ensure policies, processes and protocols are in place to that directs and supports the person-centered planning process and mitigates potential conflicts of interests.

- **Updated language from Functional Assessment Instrument (FAI) to Functional Eligibility Instrument (FEI) (excluding IDD)**

- **Proposed Language Allow Military Individuals and Immediate Family to Bypass Waitlist Upon KDADS Approval.**

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

   b. Participants may supersede the waiting list process if they fall into one of the following groups:
      - Military participants and their immediate dependent family members (as defined by IRS) who have been determined program eligible may bypass waitlist upon approval by KDADS if the individual meets the following criteria:
         - A resident of Kansas or has maintained residency in Kansas as evidence by tax return or other documentation demonstrating proof of residency
         - Must be active or recently separated (within 30 days) military personnel or dependent family members who are eligible to receive TriCare Echo
         - Have been receiving Tricare Echo at the time of separation from the military
         - Received an honorable discharge as indicated on the DD form 214

- For the purpose of the military inclusion, IRS defines immediate family as a spouse, child, parent, brother or sister of the individual in the military (IRS 1.25.1.2.2).

- **Clarified Service Plan Development; and Roles and Responsibilities of MCO (made the roles and responsibilities more clearly defined)**

a. All applicants for program services must undergo an assessment to determine functional eligibility for the program. The functionally eligibility instrument (FEI) (referred to as BASIS for IDD) is utilized to determine the level of care eligibility for the HCBS program. The state's eligibility contractor conducts the assessment of the applicant within five (5) business days of the referral, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. Participants are informed of services options available through the program by the MCO during the process of plan of care development. The participant will indicate his/her choice to receive home and community based services on the Participant Choice Form or the Integrated Service Plan/Plan of Care (ISP/POC). This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the participant's needs. During the plan of care development, the MCO will complete a needs assessment for the participant that will identify the necessary services to meet the needs of the participant.

b. The Integrated Service Plan or Plan of Care (ISP/POC) is developed during a face-to-face meeting with the participant, guardian (if applicable), the MCO and any selected representatives that the participant chooses to be involved. The location of the meeting is normally in the participant's home but arrangements can be made for another location if the participant desires. Date and time is always coordinated based on the convenience of the participant and the participant's representative, if applicable. The initial POC must be developed within seven (7) working days of financial eligibility determination and must include the MCO informing the participant of all available service options and providers for whom the participant can access. The development of the POC is finalized upon participant review and signed authorization. A copy of the POC developed during the face-to-face meeting will be provided to the participant at the time of the meeting. The participant must sign an acknowledgement that the MCO has informed him/her of all service options and available providers of those services. Services provided are based upon the needs of the participant identified through the needs assessment and clearly documented on the participant's Plan of Care (POC). The in-person health plan, needs assessment, and plan of care must be completed to allow the participant to begin receiving services within fourteen (14) working days of financial eligibility determination.

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

d. A participant's POC is developed based on the information gathered from the following:
   - Functional Eligibility Assessment
   - Needs Assessment
   - Health Assessment, if applicable

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

f. With the participant's approval, family participants or other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development and implementation of the 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.

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

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

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

j. 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 POC, the identified service tasks to be performed indicated from the needs assessment, and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated durable power of attorney, guardian, and conservator.

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

- **Updated projected numbers of annual unduplicated individuals served.**

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- **Kansas Response to DOL Rule**
    a. The State continues to consult with the US Department of Labor on the applicability of the DOL's new interpretation of the companionship exemption on Kansas self-directed programs. The DOL has delayed its enforcement of the rule by six months (to July 1, 2015).

- **Proposed Reserve Capacity to Serve Waiver Eligible Participants Admitted to an Institution for a Temporary Stay**

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

- **Consider proposing standardizing definition of monthly utilization requirements for HCBS programs, *pending CMS guidance*.**

- **Proposed Standardized WORK Program Transition Language for all HCBS program**
    a. HCBS program participants who have participated in the WORK program have the option to return to the program and bypass the waitlist if the program maintains a waitlist. Consistent with CMS required annual eligibility redetermination; participants must be reassessed within 90 days of leaving the WORK program in accordance with program eligibility level of care requirements. If the consumer is determined to not meet level of care eligibility, KDADS will terminate services using established eligibility process, including appeal rights.