Introductions & Member Updates
Brandon Fletcher, Business Development Manager and Matt Johnston with Maxim Health Care stated they were expanding services.
Options Services will be moving to a new location soon.
Lakemary Center announced they have a case manager position open.
Lois Ferguson who serves on the Johnson County Transition Council stated the next meeting will be November 9th at 6:00-7:30. She will be sending a flyer later.
Lorraine Dold, Another Day talked about the RFP for FMS agencies. There are now 26 in the state and she believes this may be reduced to only four by July 2017.

Provider of the Month Award
The Certificate of Excellence for October was awarded to Erin Crapser for her advocacy on behalf of a young man and his mother to retain parental rights and receive the services most appropriate to meet his needs. This young man is transitioning from another waiver, and Erin dedicated hours of time attending meetings, making phone calls and sending emails/letters without the ability to bill or be reimbursed for her time. It appeared every door was closed to the possibility of this mother being forced to surrender her rights in order for her son to receive services, but Erin kept pushing and calling to get those in authority to do the right thing. CONGRATULATIONS!
Please continue to send nominations to any CDDO team member.

Guest Presenter
- Adverse Incident Reporting System (AIR) by Colin Rork, KDADS Program Integrity and Compliance staff. The AIR form can be accessed from the KDADS home page by going to quick links at the bottom right part of the screen. There is a tutorial to assist with filling out the form. He went through the FAQ’s from the website. This form goes to KDADS staff and the MCO. The form is a work in progress until the submit button is hit. Once it is sent, it cannot be changed. He said that this does NOT replace the APS or CPS report if needed. Anna also mentioned that the CDDO still needs the critical incident report. Colin’s email phone/email address is 785.296.4740 colin.rork@ks.gov
CDDO Updates

- Johnson County Affiliates Meeting (monthly)
  - 11.10.16 – Department of Labor Final Rule – Wage & Hour Training for I/DD Providers on meeting requirements of the Overtime Exemption Rule that goes into effect on 12/1/16 by Kyle B. Russell, Attorney at Law, Jackson Lewis, P.C.

About Kyle Russell - Counsel in the Kansas City Region office of Jackson Lewis P.C. He represents employers in administrative charges and lawsuits involving a wide variety of statutory and common law discrimination and retaliation cases.

Mr. Russell has also defended wage and hour collective and class actions involving alleged misclassification, off-the-clock work, failure to provide required meal and rest breaks, and failure to pay wages when due. He also has extensive experience prosecuting violations of covenants not to compete by former employees. In addition to employment litigation, Mr. Russell has commercial litigation experience defending multi-district and state-law consumer class actions and governmental investigations.

Mr. Russell has experience training managers on a wide variety of employment law issues, including harassment, discrimination, retaliation, workplace violence, the Americans with Disabilities Act, and the Family & Medical Leave Act. He has also advised employers and assisted with the implementation of nationwide arbitration agreement programs.

Prior to joining Jackson Lewis, Mr. Russell practiced at a Midwest law firm and previously spent eight years as in-house counsel for litigation, records management and legal systems for a Fortune 500 diversified financial services company, where he was responsible for developing and implementing records management, litigation hold and consumer arbitration programs.

- 12.8.16 – Johnson County Mental Health and Community Behavioral Health Team (JCDS/JCMH Collaborative)

- CDDO/KDADS Quarterly Calls hosted at JCDS Elmore Center, 9:30 AM to Noon
  - October 20, 2016 – RSVP to Gail Lauri gail.lauri@jocogov.org
  - January 19, 2017
  - April 20, 2017

Quarterly BASIS Training Schedule – Elmore Center, Room 111
- 11.1.16 10:00 am -12:00 pm
- RSVP to Gail Lauri gail.lauri@jocogov.org

QMS Staff Update
- Rhonda Gabel is no longer with QMS. Contact Information for Jeanne Davied: Jeanne.davied@ks.gov 620.231.5300.

Advocacy Updates (PACK/InterHab/ANCOR)
Update from Marilyn Kubler
As a parent, ward or friend of an individual with IDD or a provider we encourage you to testify at the Robert (Bob) Bethel Oversight Committee. It is most effective to testify if you are a parent or guardian providing care to your child/adult. Here are a few helpful tips.
Keep it short – one page is best – stick to one topic – send copies of your testimony to the members of the committee and make about 50 copies to hand out at the meeting the day of the meeting. You will need to notify the Secretary of the Chairman, in this case it is Erica Haas. Her email address is: Erica.Haas@KLRD.ks. If you are going to testify in November you must let Ms. Haas know by November 6th. You will present your testimony November 19th at the capitol building in Topeka. She will notify you of the room and time to be there.

The members of the Oversight Committee and their emails are: Dan.Hawkins@house.ks.gov (he is the chairman); Laura.Kelly@senate.ks.gov; jimdenning@discoveryvision.com; jim.ward@house.ks.gov; willie.dove@house.ks.gov; Barbara.ballard@house.ks.gov I know there are many things concerning all of us, as was clearly stated by parents and providers at our recent Candidate Forum, Oct. 6. You can always send your comments to this committee, at any time, as they read their emails.

State Updates/Workgroups/Policies

- Laura Liestra no longer with the agency. Cindy Wichman, formerly with Big Lakes CDDO is joining staff as the HCBS Program Manager (Susan Fout’s position)
- CMS Visit to Kansas – 10/24-10/28
  - Meeting with KDADS, MCO’s, providers, others? Anna will find out who can attend and send out information.
- Crisis and Exception Policy – comments due to KDADS by 10.16.16
- HCBS Final Rule Bi-weekly Calls @ Noon
  - Hosted by KDADS
- Medicaid Functional Eligibility Instrument-I/DD (MFEI-I/DD)
  - Pilot new tool 2017.
  - Rollout of new tool statewide targeted for 2018.
- HCBS Final Settings Workgroup
  - Recommendations published on how state will come into compliance in the following 4 areas: Day services/Sheltered workshops/Person Centered Supporting Planning/Alzheimer’s & Dementia Programs
  - On-site assessments lead by KDADS QMC staff – just requested list of licensed day service providers
- State transition plan completed and posted for public comment before 12.31.16.

Comments from Susan Fout, Commissioner Behavioral Health Services: I want to thank you again for your hard work and dedication in making recommendations for the Kansas Final Settings Rule Transition Plan. The combined subgroup reports are attached. We are now reviewing these recommendations. KDADS will provide a response to each recommendation on our website (https://www.kdads.ks.gov/commissions/home-community-based-services-hcbs/hcbs-waivers). We expect these responses to be posted on or around October 31, 2016.

I want to also remind you that Transition Plan progress for all states (and their plans) can be tracked by visiting https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/statewide-transition-plans.html At this point, five states have initial approval, one has final approval, and 44 states along with the District of Columbia are at the same stage as Kansas: Clarifications and/or Modifications required for Initial Approval (CMIA).

If you have additional comments related to the Transition Plan, your input is always welcome at susan.fout@ks.gov. 785.296.0256
Other Items


Marilyn discussed a capacity issue.
Anna said the CDDO is working on BCI accuracy and to remind affiliates to respond to referrals and remember to send SAF’s to keep data up to date.

Next Johnson County Affiliates Meeting – November 10, 2016
KU Edwards Campus
Regnier Hall Room #255
<table>
<thead>
<tr>
<th>BHS</th>
<th>HCBS</th>
<th>OPTION</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Law Enforcement Involvement:</td>
<td>Any communication or contact with a public office that is vested by law with the duty to maintain public order, make arrests for crimes and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.</td>
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<tr>
<td></td>
<td></td>
<td>Misuse of Medications:</td>
<td>The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.</td>
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<tr>
<td></td>
<td></td>
<td>Natural Disaster:</td>
<td>A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life.</td>
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<td></td>
<td></td>
<td>Neglect:</td>
<td>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.</td>
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<td></td>
<td></td>
<td>Seclusion:</td>
<td>The involuntary confinement of a consumer alone in a room or area from which the consumer is physically prevented from leaving.</td>
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<td></td>
<td></td>
<td>Restraint:</td>
<td>Any bodily force, device/object, or chemical used to substantially limit a person’s movement.</td>
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<td></td>
<td></td>
<td>Serious Injury:</td>
<td>An unexpected occurrence involving the significant impairment of the physical condition of a consumer. Serious injury specifically includes loss of limb or function.</td>
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<tr>
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<td>Suicide:</td>
<td>Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.</td>
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<tr>
<td></td>
<td></td>
<td>Suicide Attempt:</td>
<td>A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.</td>
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<td>Other, with an Explanation</td>
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## Currently Listed Adverse Incident Reporting Categories

**August 22, 2016**

<table>
<thead>
<tr>
<th>BHS</th>
<th>HCBS</th>
<th>OPTION</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Abuse:</td>
<td>Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a consumer, including: (1) infliction of physical or mental injury; (2) any sexual act with a consumer that does not consent or when the other person knows or should know that the consumer is incapable of 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 the consumer; (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 consumer or another individual; (5) a threat or menacing conduct directed toward the consumer that results or might reasonably be expected to result in fear or emotional or mental distress to the consumer; (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.</td>
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<td>Death:</td>
<td>Cessation of a consumer's life.</td>
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<td>Elopement:</td>
<td>The unplanned departure from a unit or facility where the consumer leaves without prior notification or permission or staff escort.</td>
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<td>ER/ Hospitalization:</td>
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<td></td>
<td>Exploitation:</td>
<td>Misappropriation of the consumer's property or intentionally taking unfair advantage of an adult's physical or financial resources for another consumer's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.</td>
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<td></td>
<td></td>
<td>Fiduciary Abuse:</td>
<td>A situation in which any person who is the caretaker of, or who stands in a position of trust to, a consumer, takes, secretes, or appropriates their money or property, to any use or purpose not in the due and lawful execution of such person's trust or benefit.</td>
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</table>
Summary of Statewide Transition Plan (STP) Workgroup Recommendations

This is a summary of the recommendations made by the STP Workgroup provided as a supplement to the STP Recommendation Report with KDADS responses; responses provided considered the recommendations in their entirety.

### Dementia Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
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<tbody>
<tr>
<td>1.1. Develop guidance on person-centered care planning that is specific to persons with dementia.</td>
</tr>
<tr>
<td>1.2. Determine the financial resources and workforce needed to maintain and increase the capacity for HCBS services across Kansas.</td>
</tr>
<tr>
<td>1.3. Review and identify differences in terminology and requirements concerning person-centered planning among different provider settings.</td>
</tr>
<tr>
<td>1.4. Determine the financial resources and workforce needed to maintain and increase the capacity for HCBS services across Kansas.</td>
</tr>
<tr>
<td>1.5. State Assistance in Transitioning HCBS Consumers in Non-Compliant Settings</td>
</tr>
<tr>
<td>1.6. Allow for stakeholder review on Right to Appeal language.</td>
</tr>
<tr>
<td>1.7. KABC recommends that the state review and adopt a &quot;right to rent&quot; statute for Medicaid waiver participants, similar to public housing</td>
</tr>
<tr>
<td>1.8. KABC recommends that a complimentary internal hearing and process be created for older consumers as well as the right to an external hearing, such as an administrative state fair hearing.</td>
</tr>
<tr>
<td>1.9. Any verbal assurance/promise made to an older adult or legal representative at the time of lease is required to be incorporated into the terms of the lease agreement.</td>
</tr>
<tr>
<td>1.10. KABC recommends that individuals should not be automatically restricted based on a diagnosis of dementia or when renting or purchasing care in a &quot;memory care&quot; or &quot;adult day care&quot; setting. Any and all restrictions should be subject to the requirements of modification and be laid out in detail with supporting documentation in the person-centered service plan.</td>
</tr>
<tr>
<td>1.11. KABC recommends that the state set legal requirements for dementia care staffing ratios and training.</td>
</tr>
<tr>
<td>1.12. KABC recommends that the state use the planning process to create the next generation of health promoting settings and services which will serve older adults with dementia and meet the requirements of the HCBS final setting rule</td>
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</tbody>
</table>

### 2. Day Services

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>2.1. Kansas is an employment first state and we encourage everyone to consider employment as the first option.</td>
</tr>
<tr>
<td>2.2. Anyone participating in day services, and their natural supports, should receive annual counseling and training on benefits, other options, and resources available to help them achieve employment goals.</td>
</tr>
</tbody>
</table>
| 2.3. Day service setting- Individualized Community Integrated Day Services: Recipients have
2.4. Day service setting- Facility Based Day Services: Day Services provided in a facility setting only when a person needs time-limited pre-vocational training, and only when such training is not available in community settings.

2.5. Day service setting- Individualized Day Service Plan Due to Exceptional Needs / Day service Exceptions based on individualized, ongoing need due to health/behavioral need or operation of a home based business.

2.6. Final decisions should be based on data

2.7. Recommendation to Legislature to provide funding for the systematic changes needed to meet the needs of all individuals.

2.8. Create a rate structure reflective of a business model that maintainable for providers and supports the outcomes the state wants.

2.9. Training should be available for providers, including direct care staff, about changes

2.10. Certification for day services providers – all providers (including current) are/will be certified as part of certification, providers share plans for ensuring services are community integrated.

2.11. Accountability and communication; feedback loop to stakeholders

2.12. Goods and services option- allow for use of waiver services to purchase vocational instruction (welding lessons, classes, etc.)

2.13. Technical assistance- PCSP utilization, family members and guardians about changes

2.14. Currently, when a provider is successful at achieving employment outcomes, they are penalized; this barrier should be removed.

3. Non-Integrated Employment Settings Recommendations

3.1. Additional funding and resources to is needed to ensure full compliance with the new Final Rule. The state must calculate and fund a sufficient fiscal note to accomplish Final Rule implementation.

3.2. There should be no requirement that providers submit transition plans until alternative Waiver services are finalized. Kansas needs to draft Waiver amendment language immediately in order to develop the menu of services which will offer Kansans the alternatives needed to accomplish compliance with the Final Rule.

3.3. The “Final Rule Transition & Remediation Timeline” should be changed. Currently, this timeline, as one example, has providers submitting “remediation plans” to the state even though Kansas’ Final Rule plan has not been approved by CMS.

3.4. Service definitions proposed by this subgroup (see full recommendations document) need to be consistent with other programs, rules and definitions used by the state. Terms need to mean the same thing.

3.5. There should be a specific effort to ensure there are no unintended consequences harming or adversely affecting the resources to carry out the Final Rule.

3.6. Systems change should be specific, incremental, intentional and across departments and state agencies. As an example, we know of no current disability program or support that has the current capacity to absorb a huge influx of referrals that could result from transitions driven by the Final Rule. We need to be cognizant of these limitations.

3.7. The state should tap existing expertise as they develop all of the needed tools and steps to comply with the Final Rule. This expertise includes providers, self-advocates, advocacy
organizations, people with disabilities and families. The state needs to partner with these experts. Engagement with stakeholders needs to immediately occur to review those draft Waiver amendments prior to their submission for public comment.

### 3.8. Develop an assessment process to ensure that the most integrated setting is achieved on an individualized basis. Such a process must be free from conflicts of interest, address the needs of the individual, and conform to the Final Rule.

### 3.9. An overriding goal must be preserving and expanding service capacity in order to conform to the Final Rule. This does not mean simply preserving the status quo. It means preserving and expanding the capacity to empower and serve Kansans with disabilities in the most integrated setting. Doing this will take time, money and immediate attention by Kansas.

### 3.10. State should adopt the supported employment Waiver Integration Stakeholder Engagement (WISE) 2.0 workgroup recommendations for a new supported employment HCBS program, as outlined in this report. (See full recommendations report.)

### 3.11. The entire system should be incentivized in order to fund the desired outcome of increased competitive, integrated employment for people with disabilities of all working ages. Kansas needs to funds the outcomes it desires. According to Kansas public policy, competitive, integrated employment is supposed to be the first, and desired, option. As one example, disability provider payments could be incentivized toward the outcome of competitive and integrated employment and perhaps away from a simple fee for service model.

### 3.12. Kansas public policy needs to be evaluated to ensure it is consistent with the Final Rule toward the goal of community-based, integrated services. As an example, Article 63 envisions facility-based services. Rates and supports will need to be individualized in order to obtain the principles detailed in this report.

### 3.13. Policy and procedure changes need to ensure that non-integrated employment settings be limited to prevocational supports, be time-limited, goal-oriented, person-centered, and used only when it is truly the most integrated setting. This stated policy to conform to the Final Rule mandate cannot be in name only. Kansas policy and procedures need to contain effective accountability mechanisms in order to ensure these principles are accomplished. Rates and supports will need to be individualized in order to obtain the principles detailed in this report.

### 3.14. Kansas public policy and procedure should focus on self-direction for disability services. This has been a cornerstone of Kansas disability policy and has been contained in Kansas law since the late 1980’s [NOTE-insert the exact KSA HERE]. However, it has not been effectuated. This law focuses on self-direction, increased autonomy and control of funding for persons with disabilities to access their needed services and supports.

### 3.15. Detailed, on-going, extensive and robust outreach, communication and education plans must be developed and implemented regarding the Final Rule and its impact in Kansas. People with disabilities, families, many providers and support staff are completely unaware of how the Final Rule will impact their lives.

### 3.16. Recommend the creation of cross-age, cross-disability independent navigation, ombudsman and facilitation supports to help address the complexities of HCBS and related supports and activities, which have gotten more complex with the Final Rule. As an example, the WISE 2.0 subgroup of the services definition group recommended that TERF specialists (Transition, Employment, Resource Facilitation) be established and funded. The WISE 2.0 groups have also recommended navigation and ombudsman services. (See full recommendations report.)
3.17. Kansas should appoint a residential settings workgroup to examine changes needed to those settings in order to make them conform to the Final Rule.

### 4. PCSP

#### Recommendation

| 4.1. | Cost | Identify costs associated with compliance and attach a fiscal note to KDADS budget recommendations |
| 4.2. | Time | Need more time to work on this and develop templates & guidelines |
| 4.3. | Transparency | Current status, outcome of assessments, stakeholder engagement. |
| 4.4. | Conflict of Interest | Need more guidance related to conflict of interest. Create policies to mitigate COI in IDD & SED TCM service. |
| 4.5. | Conflict Resolution | Identify strategies for conflict resolution |
| 4.6. | State Statutes, Regulations, or Policies | Require regulations and statute to reflect requirements of PCSP. Identify potential solutions to integrate ISP with PCSP to reduce overassessment of participants. |
| 4.7. | Oversight | Assure state and provider policies are compliant with the Final Rule, clarify CDDO role in oversight, audit process to assure PCSPs meet the rule, and process for reporting non-compliance with the Final Rule. |
| 4.8. | System Access | Needs to be a singular, identified PCSP/ISP process. |
| 4.9. | Initial & Ongoing Training | Require initial & ongoing training of the documenter (qualification) |
| 4.10. | Consistent Training Model | Identify a consistent training model of PCSP statewide; prior to implementation of the new process, annually thereafter. |
| 4.11. | Stakeholder Education | Stakeholder education is standardized so everyone gets the same information & Comprehensive educational guide about PCSP |
| 4.12. | Addressing COI | In order to address COI – whenever possible the participant will facilitate their own PCSP; if unable their designated representative will facilitate. Qualified persons will document the PCSP; allow this person to work across waivers. |
| 4.13. | MCO's Role | MCO’s need to be a team member for the PCSP team |
| 4.14. | Preparation Meeting | Designated entity should attempt to conduct a preparation meeting with participants before their PCSP meeting. Designated entity should check for participant understanding throughout the PCSP meeting |
Q&A Regarding HCBS Providers’ Rate Study
Reporting Template     10.6.16

Process Questions

1. Why do we have to do this?
   a. The purpose of this template is to assess the adequacy of the Medicaid rates for Kansas’ HCBS Waiver services.

2. Who exactly is requiring this rate study? You are stating that the "State" is requesting this information. Which branch?
   a. The Kansas Department of Health and Environment (KDHE) has contracted with Optumas, an actuarial consulting firm, to assess the adequacy of HCBS payment rates.

3. Why don't we just send you our tax return?
   a. To keep information consistent across providers and properly assess the adequacy of the HCBS payment rates, we are looking for the information specifically requested on this template. We would be happy to receive any documentation in addition to the completed template.

4. So on the taxes return what address do we sent them to. Thanks.
   a. Tax returns and any additional documentation should be emailed to chris.dickerson@optumas.com and tim.doyle@optumas.com. Alternatively, a hardcopy may be mailed to Optumas at 7400 E. McDonald Dr. Suite 101, Scottsdale, AZ 85250.

5. The rates for the TBI waiver have not been increased since 1993. How will that be factored in?
   a. The purpose of this template is to assess the adequacy of the Medicaid rates paid for Kansas’ HCBS Waiver programs as they currently stand. We welcome any comments that could assist in this goal on tab |5. Comments| in the template.

6. How will you take into account the number of people not utilizing all authorized hours because they cannot find people for the rates available?
   a. Thank you for raising this concern; we will discuss this further with KDHE and consider this as part of our rate study. We welcome additional comments that could assist our goal of assessing rate adequacy on tab |5. Comments| in the template.

7. Is outside revenue considered by CMS in the rate setting process? What is the intent of providing this information for this study?
   a. The purpose of this template is to assess the adequacy of the Medicaid rates paid for Kansas’ HCBS Waiver programs. We are considering all related information to assist this goal. We have included non-Medicaid revenue and expenses on this template with the goal of having tab |4. Summary| tie to your organization’s financial reporting.

8. The IDD waiver has recently reported revenue and expenses by service in a rate study. Why is this information not being used?
   a. Optumas has been contracted to conduct a study of rate adequacy for Kansas’ HCBS services. The information requested in this template is necessary to conduct this study and our process is completely independent to the previous study.
9. Where can we access the recording of the template walkthrough webinar?
   a. The recording of the template walkthrough webinar is posted on KanCare’s website, both on the home page and the provider events page. The direct link to the recording is https://www.youtube.com/embed/3HANQybp-AU?rel=0

10. What is the formula you will be using for rates? Will you even change rates based on these questions? Will you be using any national rate studies or will you be making this up yourself?
   a. We will be considering multiple sources of data for our final report. The data received from providers in this template will account for a substantial portion of the study. Optumas will convey findings to the State and rate change policy decisions will be at the State’s discretion.

11. How will this template be provided to providers?
   a. A notice about the template and access instructions were sent to providers by KDHE on 9/23/2016 and is available online at http://www.kancare.ks.gov/provider_events.htm

12. Is this still due Oct. 17th?
   a. The expectation is for all templates to be returned completed by October 17, 2016 in order to complete the study in an appropriate time.

13. Can we contact you outside of this webinar?
   a. Questions not addressed here or in the review should be emailed to chris.dickerson@optumas.com and tim.doyle@optumas.com.

14. The document says the state policy is to consider outside revenue sources in establishing rates. Is this supplanting the rates approved by CMS?
   a. The purpose of this template is to assess the adequacy of the Medicaid rates paid for Kansas HCBS Waiver programs. We are considering all related information to assist toward this goal. Any potential changes to rates will be addressed by the State.

15. What happens if providers miss the deadline by a few days?
   a. Providers are asked to submit the completed template by 10.17.16. If you have a unique situation that causes you to need a brief extension of the deadline, please send a request that explains your situation, and proposes a short-term/specific alternative submission date, to Elizabeth Phelps at KDHE (ephelps@kdheks.gov). Unless a specific, time-limited extension is approved, the October 17th deadline applies.

Feedback

1. We do not have the staff to spend time in this because our rates are inadequate.
   a. The goal of this template is to assess this information on a statewide level. Completing this template will help provide that information and can only help in determining rate adequacy. We developed this template to be a user friendly and efficient way to capture information we thought would already be available to providers.

2. Profit/Loss does not always reflect the Cash position - especially when you take into consideration claims still not paid...
   b. The goal of this template is to assess the adequacy of the Medicaid rates paid for Kansas’ HCBS Waiver programs. Given that we are asking for CY14 and CY15 data, and based on our experience with HCBS in other states, the bulk of the claims should be paid for these time periods. Please provide figures on an accrual/incurred basis, which would account for any claims not yet paid.
As discussed on the call, Optumas will validate the revenue reported based on the data available.

3. Clients that have waivers - Medicare does not cover their waiver services  
   a. We are in agreement that waiver services are primarily Medicaid responsibility, but understand that organizations may also provide other services paid by Medicare or other insurance. Non-Medicaid revenue can be reported in cells C23:D29 on tab |1. Revenue|, separate from waiver service revenue.

4. Recently there were significant budget cuts in the CMHC system that won’t be reflected on this template.  
   a. We welcome any comments that could assist in determining adequacy of HCBS payment rates on the tab [5. Comments] in the template. These comments will be assessed carefully, and additional adjustments may be applied to the base data in order to account for such instances.

Patients and Visits

1. What is a Unique Medicaid pt.?  
   a. A unique Medicaid patient is an unduplicated count of individuals who received Medicaid services. If you offered services to one person with the Autism Waiver, once a month in 2014, then on the [3. Services Rendered] tab, cell C11 should have “1” and cell C27 should have “12”.

2. How would you like me to count Unique Patients if they spilt between HCBS and Non-Medicaid. IE if they were approved in the middle of the year?  
   a. Under this scenario, we would like the individual to count once in the Non-Medicaid table and once in the Medicaid table.

3. How do you define a visit for HCBS services? Is there a certain number of hours per visit? Curious if is 1 for each encounter or based on billed units? HCBS day and res services and SHC are tracked in different kind of units (days, 15 min units). How do you suggest we report these units in the visits section? Unclear and does not match how billing is conducted for IDD waiver. For a Day Service, would it be how many days one person attended or how many units?  
   a. For the purposes of this study, a visit is a patient encounter (either in-person or virtual). It should not be billed units, as different services have a wide range of unit values. Instead, we would like to see the count of patient interactions, which are sometimes considered patient-days. For example, if a provider has a residential patient that they see every day of the month, we would like that individual to count as 30 (or 31) visits in the given month. If a provider has a patient that receives services one day a week, we would like each of those weekly encounters to count as one visit, regardless of whether the patient is given 15 minutes of services or an hour of services.

4. Services Rendered tab - that is asking for a patient count at the top and patient days at the bottom - is that right? Related to above question - for a patient count you want that for our year end, and the patient days for the entire year?  
   a. This is correct. If you offered services to one person with the Autism Waiver, once a month in 2014, then on the [3. Services Rendered] tab, cell C11 should have “1” and cell C27 should have “12”.
5. Under numbers served, do you want the grand total from each month served? We service the same people each month so if we serve 30 people would that total 30 x 12 months = 360 served?
   a. “Visits” should include the entire year. If you serve 30 people every day for a full year, you would report 30 x 365 = 10,950. “Unique Patients” should be the unduplicated count of patients served. In this example you would report 30.
   a. For the purposes of this study a visit is a patient encounter (either in-person or virtual). It should not be billed units, as different services have a wide range of unit values. Instead, we would like to see the count of patient interactions, which are sometimes considered patient-days. For example, if a provider has a residential patient that they see every day of the month, we would like that individual to count as 30 (or 31) visits in a month. If a provider has a patient that receives services one day a week, we would like each of those weekly encounters to count as one visit, regardless of if the patient is given 15 minutes of services or an hour of services.
7. By "patient" do you mean MCO Member?
   a. A patient would be anyone receiving HCBS services. They could be enrolled in a Medicaid MCO, Medicaid FFS, or for the non-Medicaid tables, they could be commercial/Medicare/private pay.
8. If a person private pays for day service, is that a non-HCBS service?
   a. Revenue received from a private pay patient or commercial insurance plan can be reported on tab |1. Revenue| in rows 24 and 25 (“Commercial”, “Patient Payment”). Visits and patient counts would be reported in the non-Medicaid table on |3. Services Rendered|. Whether it is considered HCBS or non-HCBS would depend on the specific service provided.
9. Under the Unique Medicaid not unique category are you wanting number of patients or what?
   a. Tab |3. Services Rendered| should include Medicaid data on the left tables, with the number of patients in the top table and the number of visits in the bottom table. If you offered services to one person with the Autism Waiver, once a month in 2014, then on the |3. Services Rendered| tab, cell C11 should have “1” and cell C27 should have “12”.
10. tcm’s do not bill only for visits but a billable service. how do I answer the # visits?
    a. We request that you complete this to the best of your ability. If possible, please report the number of days of service provided to each patient.

Applicable Providers

1. Does this apply to SED waiver? We are not CDDOs, nor affiliated with CDDOs.
   a. All providers of services under any of Kansas’ seven waivers are requested to report their information using this template. The space created on the |Instructions| tab for declaring CDDO affiliation does not necessarily apply to all such providers, and should be left blank when no arrangement of this type exists.
2. Do Targeted Case Managers for the IDD waiver have to participate in this study?
   a. All providers of services under any of Kansas’ seven waivers are requested to report their information using this template. If a provider’s services are limited to Targeted
Case Management, which is a State Plan service, the provider does not have to submit the template.

3. If an agency provides the "pay and bill" function for several independent Autism providers, can we complete one report for those individual workers?
   a. If billing and reimbursement occur through a single entity with one NPI, then the information for independent providers may be reported using a single template. If billing and reimbursement occur through multiple NPIs, the template should be completed for each NPI.

4. We received a request to complete the survey for our foster care services. Should we submit the survey for this non-HCBS service?
   a. This template includes cells for reporting revenue and expenses for non-HCBS waiver services in addition to HCBS waiver services. If your organization provides HCBS services, please fill out the template with HCBS revenues, expenses, and services in the HCBS rows, and non-HCBS information in non-HCBS rows. If your organization does not provide services under any of Kansas’ seven waivers, then there is no need to complete the template.

5. My company runs a nursing home, senior apartments, and a community center. Do I report revenue and expenses for all three?
   a. If all of your locations operate with the same NPI, they should all be included on the same template. The goal of this template is to create a complete picture of revenue and expenses for your organization. You are requested to provide all pertinent information related to the operation of your organization to help us achieve this goal. Please be as specific as possible when categorizing revenue and expenses, as this will help us understand all lines of business and how HCBS waiver services fit into that overall picture.

Revenue & Expense

1. Why are you requesting revenue data, when what you need to be looking at is cost in order to determine if the rates paid currently are adequate and are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers?
   a. We plan on looking at both revenue and cost. The goal of the rate study is to determine if rates are adequate to cover the cost of services provided. By collecting data on the revenue received from these rates and the cost of the corresponding services we can make statements regarding rate adequacy.

2. Should the revenue include just the Waiver specific codes or revenue for all codes the Waiver participant receives?
   a. Please include Medicaid revenue for Waiver services in lines 10 through 17 of the Revenue tab. If a member receives non-Waiver services (e.g. Physical Therapy), please include that Medicaid revenue in line 18 of the Revenue tab.

3. Revenue for the year would only include (Dates of Services) for that Calendar year. So If I received revenue for 2013 in 2014, I would not include that in the 2014 revenue?
   a. Revenue should be reported based on the date of service, so a service provided on 12/31/13 that is paid on 1/15/14 would not be reported for 2014.
4. For the Medicare payment are you saying that we you want the Medicare B income for those years? Even if they do no pertain to HCBS residents?
   a. The Medicare revenue line is intended to capture any revenue your organization receives from Medicare. Optumas is most concerned with matching revenue and expense. If you can split your revenue and expenses to exclude just the Medicare part B components that is appropriate. If you are unable to split the information, we ask that you report all revenue and expenses in as detailed a manner as possible to allow us additional insight to your company’s operations.

5. Do we need to be consistent on how we report revenues vs expenses. For ex if we can breakdown revenues but not expenses which way should we report?
   a. Please be as detailed as possible. If revenue can be split into greater detail than expenses, split revenue into detail and report expenses as you can.

6. On tab 2, line 25: the Parent Fee is sent directly to the State, not the provider. Do you mean Client Obligation which is sent to the provider of service?
   a. Parent Fee is meant to capture any payments made from a subsidiary to a parent company or corporation.

7. The instructions say accrual basis, but in the Revenue tab in instructions it states "payments made to your provider ID". Do you want revenue earned, or payments received?
   a. Report the revenue earned, regardless if payment has been received yet.

8. Is this for Gross Revenue or Net Revenue?
   a. Please report the revenue after adjusting for recoupments.

9. There is no place on this report for adjustments. How do we account for this?
   a. Please report revenue after adjustments. If you receive $100, but $20 is recouped, please report $80. Any additional revenue, expenses, or services that cannot be included in the splits should be included in the general categories (“Other Revenue”, “Non-Service, Non-Admin Expenses” etc.) with explanations below.

10. For revenues, do we include all service codes or just Waiver specific codes?
    a. Please report Medicaid revenue for waiver specific codes in lines 10 through 17. Medicaid revenue for non-waiver codes should be reported in line 18. In addition, non-Medicaid revenue is captured in lines 23-29.

11. Does the category of service expense include indirect care such as dietary, housekeeping, laundry, etc. Should property expense be included in operation expense?
    a. The indirect services mentioned should be considered waiver expenses and should be categorized in lines 8 through 15 of the |2. Expenses| tab as appropriate. Property expenses should be included in “Operations Expenses”, line 22 of the |2. Expenses| tab.

12. As A CCRC, it is assumed that the revenue/expenses that are needed include only the home health/hcbs and not the entire organization services at every level of living
    a. Optumas is most concerned with matching revenue and expense. If you can split your revenue and expenses to include just the home health and HCBS components in the template that is appropriate. If you are unable to split the information, we ask that you report all revenue and expenses in as detailed a manner as possible to allow us additional insight to your company’s operations. Please note that since home health services are covered under the state plan they should be reported in the “Non-HCBS Service” lines.
13. Many of the grants or fund raisers providers do are specifically tied to a certain activity and aren’t available for overall operations. Where would you like them entered? In the comments section?
   a. Please enter revenue tied to a specific activity in row 29 of the |1. Revenue| tab, and explain all components of the revenue in the comment box.

Information to Include

1. We bill HCBS for our Home Health and separately for our Assisted Living. What is the focus of the template? Do we have to do both?
   a. The purpose of this template is to assess the adequacy of rates paid for all services under each of Kansas’ seven waivers. You are requested to provide all pertinent information related to the operation of your organization. Please be as specific as possible when categorizing revenue and expenses, as this will help us understand all lines of business and how HCBS waiver services fit into that overall picture. Please note that since home health services are covered under the state plan they should be reported in the “Non-HCBS Service” lines.

2. Is this for services rendered in the state of Kansas only?
   a. You are requested to provide information for all Kansas HCBS waiver enrollees, whether services are rendered in Kansas or another state.

3. If 2014 information was already provided in the earlier rate study, do we need to re-submit?
   a. Yes. The intent of this template is to gather information that is consistent across all HCBS provider types.

4. Can we report on fiscal year 2014 and 2015, not calendar years? Converting it to calendar year will not tie to anything and would be time prohibitive to do. Can we just change the certification to note that we are reporting on fiscal year?
   a. All information is requested on a calendar year basis. We apologize for any inconvenience, but aligning the time periods of all submissions is necessary to make valid comparisons.

5. If I am a provider for IDD HCBS residential and day services, when I complete this form, is it only for OUR services? Or do I need to obtain information for all doctor appointments I have taken participants to? All therapy appointments I have taken them to, etc? Is it just strictly residential and day services you want data on for my provider?
   a. Information submitted through this template should be limited to the services provided by your organization and billed through your NPI. Services provided by any separate entities (physicians, therapists, etc.) should be excluded.

6. What if you have one NPI number and multiple Medicaid provider numbers? How does that affect the reporting template?
   a. Please enter your NPI and one Medicaid provider ID on the |Instructions| tab. Additional Medicaid provider IDs and a brief explanation should be submitted using the |5. Comments| tab.

7. I have participated in HCBS waiver services only during 2016. Do you want information from me indicating 0 services and $0?
   a. If your organization did not provide any HCBS waiver services during calendar years 2014 and 2015, then there is no need to complete the template.
8. Can you please go over the multiple locations needing separate worksheets?
   a. The number of worksheets that should be submitted is based on the number of NPIs in
      use. If your organization consists of multiple locations that bill for services and are
      reimbursed under a single NPI, then filling out one template will suffice.
9. Is the CDDO required to release the organization’s NPI to affiliates or can that field be left blank?
   a. If the NPI is not available for the CDDO with which you are affiliated, please provide the
      CDDO’s name. In this case, the NPI may be left blank.
10. Do you want IDD nursing broken out from IDD personal care assistant, or all together?
    a. Revenue and expense information for services provided under the same waiver may be
       grouped together for reporting purposes.
11. I have limited clients on HCBS waiver for IDD. Residential and day habilitation services paid
    through Medicaid waiver funding. Do I lump both residential and day habilitation services? Are
    expenses to include transportation entertainment day services?
    a. Revenue and expense information for services provided under the same waiver may be
       grouped together for reporting purposes.
12. SEK 3-B HOMEMAKER; VA Attendant Care; SCA HOMEMAKER. Where would you classify this
    revenue, client count and visits on your spreadsheet?
    a. These services are not Medicaid funded services, so the revenue for them should be
       reported in the “Other Revenue” table on the [1. Revenue] tab (cells C23 to D29).
       Providers can place the revenue in the most appropriate line in that table.
Creep on Over to the Boo Bash

Please join us for a ghoulish costume contest, freaky music, and frightening food!

Wednesday, October 26th
6:00-8:30 PM
Lenexa Community Center
13420 Oak, Lenexa, KS 66215

DJ: John Todd
Light Refreshments
$1 Donation
No RSVP Required
Awards for Best Original Costumes!!

Sponsored by Friends of JCDS & JCDS Service Coordinators
Questions: Marie Figoni Daniels
913-826-2347

** Caregivers (friends, family members, personal assistants, & residential service providers) are responsible for providing any and all needed supervision and/or assistance in the dance and the parking lot before, during, and after the dance. Thank-you caregivers for helping to make this a safe event for everyone!!