

KANSAS MEDICAID STATE PLAN

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30-10-200. Intermediate care facilities for mentally retarded (ICF's-MR) definitions. (a) "Accrual basis of accounting" means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(b) "Adequate cost and other accounting information" means that the data, including source documentation, is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash pay out memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required costs data, financial and statistical records shall be maintained in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

(c) "Agency" means the Kansas department of social and rehabilitation services.

(d) "Ancillary services and other medically necessary services" mean those special services or supplies for which charges are made in addition to routine services. This includes oxygen. The purchase of oxygen gas shall be reimbursed to the oxygen supplier through the social and rehabilitation services' fiscal agent or the fiscal agent may reimburse the ICF-MR directly if an oxygen supplier

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is unavailable.

(e) "Approved staff educational activities" means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of client care in an ICF-MR. These activities shall be licensed when required by state law.

(f) A "client day" means that period of service rendered to a client between the census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any medicaid/medikan or non-medicaid/medikan client who was not in the home. The census-taking hours consist of 24 hours beginning at midnight.

(g) "Common ownership" means that any individual or an organization holds 5% or more ownership or equity of the ICF-MR and of the facility or organization serving the ICF-MR.

(h) "Control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(i) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(j) "Costs related to client care" means all necessary and proper costs, arising from arms-length transactions in accordance with general accounting rules, which are appropriate and helpful in developing and maintaining the operation of client care facilities.

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and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-218, K.A.R. 30-10-219, K.A.R. 30-10-220, K.A.R. 30-10-221, K.A.R. 30-10-222, K.A.R. 30-10-223, K.A.R. 30-10-224 and K.A.R. 30-10-225.

(k) "Costs not related to client care" means costs which are not appropriate or necessary and proper in developing and maintaining the ICF-MR operation and activities. These costs are not allowable in computing reimbursable costs.

(l) "Extra care" means temporary care required by a client that takes more time, services and supplies than the care provided an average ICF-MR client. Extra care requires prior authorization before reimbursement.

(m) "General accounting rules" mean the generally accepted accounting principles as established by the American institute of certified public accountants except as otherwise specifically indicated by ICF-MR program policies and regulations. Any adoption of these principles does not supersede any specific regulations and policies of the ICF-MR program.

(n) "Inadequate care" means any act or failure to take action which potentially may be physically or emotionally harmful to a recipient.

(o) "Inspection of care review of intermediate care facilities for the mentally retarded" means a yearly, client-oriented review of only medicaid/medikan clients, conducted by a team from the Kansas department of health and environment consisting of a nurse,

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a social worker, and a medical doctor, to determine whether those clients' needs are being met.

(p) "Intermediate care facility for the mentally retarded" means a facility which has met state licensure standards and which:

- (1) Is primarily for the diagnosis, treatment, or habilitation of the mentally retarded or persons with related conditions; and
- (2) provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or habilitative services to help each individual function at that person's greatest ability.

(q) "Levels-of-care model" means a residential model with five residential facility levels established by service intensity categories and size of facilities. The following specifies the size of facility limits:

- (1) Small facility (four through eight beds);
- (2) medium facility (nine through 16 beds); and
- (3) large facility (greater than 16 beds).

(r) "Mental retardation" means subaverage general intellectual functioning which originates in the developmental period and which is associated with impairment in adaptive behavior as defined by the 1983 revision of classification in mental retardation authored by the American association of mental deficiency.

(s) "Net cost of educational activities" means the cost of approved educational activities less any grants, specific donations or reimbursements of tuition.

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(t) "Non-working owners" means any individual or organization having 5% or more interest in the provider, who does not perform a client-related function for the ICF-MR.

(u) "Non-working related party" means any related party as defined in K.A.R. 30-10-200 who does not perform a client-related function for the ICF-MR.

(v) "Organization costs" mean those costs directly incidental to the creation of the corporation or other form of business. These costs are intangible assets in that they represent expenditures for rights and privileges which have value to the enterprise. The services inherent in organization costs extend over more than one accounting period and must be amortized over a period of not less than 60 months from the date of incorporation.

(w) "Owner-related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with a 5% or greater interest in the provider or any related party as defined in K.A.R. 30-10-200, whether the payment is from a sole proprietorship, partnership, corporation, or non-profit organization.

(x) "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

(1) Is attributable to:

(A) Cerebral palsy or epilepsy; or

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(B) any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(2) is manifested before the person attains age 22;

(3) is likely to continue indefinitely; and

(4) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction; and

(F) capacity for independent living.

(y) "Physician extender" means a person registered as a physician's assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided and who is working under supervision as required by law or administrative regulation.

(z) "Plan of care" means a document which states the need for care, the estimated length of the program, the methodology to be used, and expected results.

(aa) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of

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time. The projected cost report is based on an estimate of the costs, revenues, resident days, and other financial data for the 12-month period of time.

(bb) "Projection status" means that a provider has been assigned a previous provider's rate for a set period of time or is allowed to submit a projected cost report. The provider shall submit an historic cost report at the end of the projection period to be used for a settlement of the interim rates and to determine a prospective rate.

(cc) "Provider" means the operator of the ICF-MR specified in the provider agreement.

(dd) "Psychological evaluations or re-evaluations in intermediate care facilities for the mentally retarded" means a review of the previous pertinent psychological material to determine if it is consistent with the client's present status.

(ee) "Related parties" means any relationship between two or more parties in which one party has the ability to influence another party to the transaction such that one or more of the transacting parties might fail to pursue its own separate interests fully. Related parties include parties related by family, business or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arms-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.

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(ff) "Related to the ICF-MR" means that the facility, to a significant extent, is associated or affiliated with, has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

(gg) "Representative" means legal guardian, conservator or representative payee as designated by the social security administration, or any person designated in writing by the client to manage the client's personal funds, and who is willing to accept the designation.

(hh) "Routine services and supplies" mean services and supplies that are commonly stocked for use by or provided to any client. They are to be included in the provider's cost report.

(1) Routine services and supplies may include:

(A) All general nursing services;

(B) items which are furnished routinely to all clients;

(C) items stocked at nursing stations in large quantities and distributed or utilized individually in small quantities;

(D) routine items covered by the pharmacy program when ordered by a physician for occasional use; and

(E) items which are used by individual clients but which are reusable and expected to be available in a facility.

(2) Routine services and supplies are distinguished from non-routine services and supplies which are ordered or prescribed by a physician on an individual or scheduled basis. Medication ordered may be considered non-routine if:

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(A) It is not a stock item of the facility; or

(B) it is a stock item with unusually high usage by the individual for whom prior authorization may or may not be required.

(3) Routine services and supplies do not include ancillary services and other medically necessary services as defined in subsection (d) and also do not include those services and supplies the client must provide.

(4) Reasonable transportation expenses necessary to secure routine and non-emergency medical services are considered reimbursable through the medicaid per diem rate.

(ii) "Working trial balance" means the summary from the provider's general ledger that was used in completing the cost report. This summary should contain the account number, and a description of the account, amount of the account and on what line of the cost report it was reported. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

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30-10-201. Intermediate care facilities for mentally retarded. (a) Change of provider.

(1) The current provider or prospective provider shall notify the agency of a proposed change of providers at least 60 days in advance of the closing transaction date. Failure to submit a timely notification shall result in the new provider assuming responsibility for any overpayment made to the previous provider before the transfer. This shall not release the previous provider of responsibility for such overpayment.

(2) Before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the agency shall be notified in writing concerning the change at least 60 days before the change. Failure to submit a timely notification shall result in the new provider assuming responsibility for any overpayment made to the previous provider before the transfer. This shall not release the previous provider of responsibility for such overpayment. The secretary may expressly agree in writing to other overpayment recovery terms.

(3) Any partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the provider of services. Any addition or substitution to a partnership or any change of provider resulting in a completely new partnership shall require that an application to be a provider of services be submitted to the agency.

(4) If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of services shall be submitted to the agency.

(5) Transfer of participating provider corporate stock shall not in itself constitute a change of provider. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of provider. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of provider and an application to be a provider of services shall be submitted to the agency.

(6) The change of or a creation of a new lessee, acting as a provider of services, shall constitute a change of provider. An application to be a provider of services shall be submitted to the agency. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in provider.

(b) Each new provider shall be subject to a certification survey by the department of health and environment and, if certified, the period of certification shall be as established by the Kansas department of health and environment. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective January 30, 1991.)

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30-10-202. ICF-MR provider agreement. As a prerequisite for participation in the medicaid/medikan program as an ICF-MR provider, the owner or lessee shall enter into a provider agreement with the agency on forms prescribed by the secretary. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

30-10-203. ICF-MR inadequate care. (a) When the agency determines that inadequate care is being provided to a client, payment to the ICF-MR for the client may be terminated.

(b) When the agency receives confirmation from the Kansas department of health and environment that an ICF-MR has not corrected deficiencies which significantly and adversely affect the health, safety, nutrition or sanitation of ICF-MR clients, payments for new admissions shall be denied and future payments for all clients shall be withheld until confirmation that the deficiencies have been corrected. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

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30-10-204. ICF-MR standards for participation; intermediate care facility for the mentally retarded or clients with related conditions. As a prerequisite for participation in the medicaid/medikan program as a provider of intermediate care facility services for the mentally retarded or clients with related conditions, each ICF-MR shall: (a) Meet the requirements of 42 CFR 442, subparts A, B, C and E, effective October 3, 1988, which is adopted by reference, and 42 CFR 483, subpart D, effective October 3, 1988, which is adopted by reference; and

(b) be certified for participation in the program by the Kansas department of health and environment. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

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Health Care Financing Administration, HHS

§ 442.13

Subpart A—General Provisions

§ 442.1 Basis and purpose.

(a) This part states requirements for provider agreements and facility certification relating to the provision of services furnished by skilled nursing facilities and intermediate care facilities to Medicaid recipients. The requirements apply to State Medicaid agencies and survey agencies and to the facilities. This part is based on the following sections of the Act:

- Section 1902(a)(4), administrative methods for proper and efficient operation of the State plan;
- Section 1902(a)(27), provider agreements;
- Section 1902(a)(28), skilled nursing facility standards;
- Section 1902(a)(33)(B), State survey agency functions;
- Section 1902(i), circumstances and procedures for denial of payment and termination of provider agreements in certain cases;
- Section 1905 (c) and (d), definition of intermediate care facility services;
- Section 1905 (f) and (i), definition of skilled nursing facility services;
- Section 1910, certification and approval of SNFs and of RHCs;
- Section 1913, hospital providers of skilled nursing and intermediate care services, and
- Section 1918, correction and reduction plans for intermediate care facilities for the mentally retarded.

(b) Section 431.610 of this subchapter contains requirements for designating the State licensing agency to survey these facilities and for certain survey agency responsibilities.

[43 FR 45233, Sept. 29, 1978, as amended at 47 FR 31533, July 20, 1982; 51 FR 24490, July 3, 1986; 53 FR 1993, Jan. 25, 1988; 53 FR 20495, June 3, 1988]

**Effective Date Note:** At 53 FR 20495, June 3, 1988, § 442.1(a), the first sentence was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.1 Basis and purpose.

(a) This part states requirements for provider agreements, facility certification, and facility standards relating to the provision of services furnished by skilled nursing facilities and intermediate care facilities, including intermediate care facilities for the mentally retarded, to Medicaid recipients.

§ 442.2 Terms.

**In this part—**  
**Facility** refers to a skilled nursing facility (SNF), an intermediate care facility (ICF), and an intermediate care facility for the mentally retarded or persons with related conditions (ICF/MR). Except where otherwise specified, "ICF" refers to both an ICF and an ICF/MR.

**Facility**, and any specific type of facility referred to, may include a distinct part of a facility as specified in § 440.40 or § 440.150 of this subchapter.

**Immediate jeopardy or immediate threat** for Medicaid certified facilities means a situation in which a facility's noncompliance with one or more conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR) poses a serious threat to patients' or clients' health or safety such that immediate corrective action is necessary. There is no substantive difference between **immediate jeopardy** and **immediate threat**.

**New admission** means the admission of a Medicaid recipient who has never been in the facility or, if previously admitted, had been discharged or had voluntarily left the facility. The term does not include the following:

(a) Individuals who were in the facility before the effective date of denial of payment for new admissions, even if they become eligible for Medicaid after that date.

(b) If the approved State plan includes payments for reserved beds, individuals who, after a temporary absence from the facility, are readmitted to beds reserved for them in accordance with § 447.40(a) of this chapter.

[43 FR 45233, Sept. 29, 1978, as amended at 51 FR 24491, July 3, 1986; 53 FR 1993, Jan. 25, 1988]

Subpart B—Provider Agreements

§ 442.10 State plan requirement.

A State plan must provide that requirements of this subpart are met.

§ 442.12 Provider agreement: General requirements.

(a) **Certification and recertification.** Except as provided in paragraph (b) of this section, a Medicaid agency may not execute a provider agreement with a facility for SNF or ICF services nor make Medicaid payments to a facility for those services unless the Secretary or the State survey agency has certified the facility under this part to provide those services. (See § 442.10) for certification by the Secretary or by the State survey agency).

(b) **Exception.** The certification requirement of paragraph (a) of this section does not apply with respect to Christian Science sanatoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

(c) **Conformance with certification condition.** An agreement must be in accordance with the certification provisions set by the Secretary or the survey agency under Subpart C of this part.

(d) **Denial for good cause.** (1) If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility.

(2) A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

[45 FR 22936, Apr. 4, 1980]

§ 442.13 Effective date of agreement.

(a) **Basic requirements.** If the Medicaid agency enters into a provider agreement, the effective date must be in accordance with this section.

(b) **All Federal requirements are met on the date of the survey.** The agreement must be effective on the date the onsite survey is completed (or on the day following the expiration of a cur-

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rent agreement) if, on the date of the survey, the provider meets:

(1) All Federal health and safety requirements; and

(2) Any other requirements imposed by the Medicaid agency.

(c) All Federal requirements are not met on the date of the survey. If the provider fails to meet any of the requirements specified in paragraph (b) of this section, the agreement must be effective on the earlier of the following dates:

(1) The date on which the provider meets all requirements.

(2) The date on which the provider is found to meet all applicable conditions of participation and submits a correction plan for other deficiencies to the State survey agency or an approvable waiver request, or both.

[45 FR 22936, Apr. 4, 1980, as amended at 53 FR 20495, June 3, 1988]

**EFFECTIVE DATE NOTE:** At 53 FR 20495, June 3, 1988, § 442.13(b)(1), was amended by removing the word "standards" and adding in its place the word "requirements," and paragraph (c) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.13 Effective date of agreement.

(c) All Federal requirements are not met on the date of the survey. If the provider fails to meet any of the requirements specified in paragraph (b) of this section, the agreement must be effective on the earlier of the following dates:

(1) The date on which the provider meets all requirements.

(2) The date on which the provider submits a correction plan acceptable to the State survey agency or an approvable waiver request, or both.

§ 442.14 Effect of change of ownership.

(a) **Assignment of agreement.** When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.

(b) **Conditions that apply to assigned agreements.** An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety requirements.

(4) Compliance with the ownership and financial interest disclosure requirements of §§ 455.104 and 455.105 of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

(6) Compliance with any additional requirements imposed by the Medicaid agency.

[45 FR 22936, Apr. 4, 1980, as amended at 53 FR 20495, June 3, 1988]

**EFFECTIVE DATE NOTE:** At 53 FR 20495, June 3, 1988, § 442.14(b)(3), was amended by removing the word "standards" and adding in its place the word "requirements," effective October 3, 1988.

§ 442.15 Duration of agreement.

(a) Except as specified under § 442.16, the duration of an agreement may not exceed 12 months.

(b) The agreement must be for the same duration as the certification period set by the survey agency. However, if the Medicaid agency has adequate documentation showing good cause, it may make an agreement for less than this period.

(c) FFP is available for services provided by a facility for up to 30 days after its agreement expires or terminates under the conditions specified in § 441.11 of this subchapter.

(d) The limitation specified in paragraph (a) of this section does not apply to hospitals with a swing-bed approval.

[43 FR 45233, Sept. 29, 1978, as amended at 47 FR 31632, July 20, 1982]

§ 442.16 Extension of agreement.

A Medicaid agency may extend a provider agreement for a single period of up to 2 months beyond the original expiration date specified in the agreement if it receives written notice from the survey agency, before the expiration date of the agreement, that extension will not jeopardize the patients' health and safety, and--

(a) Is needed to prevent irreparable harm to the facility or hardship to the recipients in the facility; or

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(b) Is needed because it is impracticable to determine, before the expiration date, whether the facility meets certification requirements.

143 FR 45233, Sept. 29, 1978, as amended at 52 FR 32551, Aug. 28, 1987; 53 FR 20495, June 3, 1988)

**EFFECTIVE DATE NOTE** At 53 FR 20495, June 3, 1988, § 442.16(b), was amended by removing the word "standards" and adding in its place the word "requirements," effective October 3, 1988.

§ 442.30 Additional requirements for agreements with SNF's participating in Medicare.

(a) The Medicaid agency's agreement with a SNF participating in Medicare must—

(1) Provide for the same terms and conditions as Medicare certification; and

(2) Be for the same duration as the Medicare certification.

(b) If the Secretary notifies the Medicaid agency that he has denied, terminated, or refused to renew a Medicare agreement with a SNF, the agency must deny, terminate, or refuse to renew its Medicaid agreement with that SNF. The denial, termination, or refusal to renew the Medicaid agreement must be effective on the same date as the denial, termination, or refusal to renew the Medicare agreement.

(c) If the Medicaid agency has terminated an agreement under paragraph (b) of this section, it may not make another agreement with that SNF until—

(1) The conditions causing the termination are removed; and

(2) The SNF provides reasonable assurance to the survey agency that the conditions will not recur.

143 FR 45233, Sept. 29, 1978, as amended at 44 FR 8753, Feb. 18, 1979)

§ 442.30 Agreement as evidence of certification.

(a) Under §§ 440.40(a) and 440.150 of this chapter, FFP is available in expenditures for SNF and ICF services only if the facility has been certified as meeting the requirements for Medicaid participation, as evidenced by a provider agreement executed under this part. An agreement is not valid

evidence that a facility has met those requirements if HCFA determines that—

(1) The survey agency failed to apply the applicable certification requirements under Subpart D, E, or F of this part or Subpart D of Part 483, which sets forth the conditions of participation for ICFs/MR;

(2) The survey agency failed to follow the rules and procedures for certification set forth in Subpart C of this part and § 431.610 of this subchapter;

(3) The survey agency failed to perform any of the functions specified in § 431.610(g) of this subchapter relating to evaluating and acting on information about the facility and inspecting the facility;

(4) The survey agency failed to use the Federal standards, and the forms, methods and procedures prescribed by HCFA as required under § 431.610(f)(1) of this chapter, for determining the qualifications of providers; or

(5) The survey agency failed to adhere to the following principles in determining compliance:

(i) The survey process is the means to assess compliance with Federal health, safety and quality standards;

(ii) The survey process uses resident outcomes as the primary means to establish the compliance status of facilities. Specifically, surveyors will directly observe the actual provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents;

(iii) Surveyors are professionals who use their judgment, in concert with Federal forms and procedures, to determine compliance;

(iv) Federal procedures are used by all surveyors to ensure uniform and consistent application and interpretation of Federal requirements;

(v) Federal forms are used by all surveyors to ensure proper recording of findings and to document the basis for the findings.

(6) The survey agency failed to assess in a systematic manner a facility's actual provision of care and services to residents and effects of that care on residents.

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(7) Required elements of the SNF or ICF survey process include all of the following:

- (i) An entrance conference;
- (ii) A resident-centered tour of facility;
- (iii) An in-depth review of a sample of residents including observation, interview and record review;
- (iv) Observation of the preparation and administration of drugs for a sample of residents;
- (v) Evaluation of a facility's meals, dining areas and eating assistance procedures;
- (vi) Formulation of a deficiency statement based on the incorporation of all appropriate findings onto the survey report form;
- (vii) An exit conference; and
- (viii) Follow-up surveys as appropriate.

(8) The agreement's terms and conditions do not meet the requirements of this subpart.

(b) The Administrator will make the determination under paragraph (a) of this section through onsite surveys, other Federal reviews, State certification records, or reports he may require from the Medicaid or survey agency.

(c) If the Administrator disallows a State's claim for FFP because of a determination under paragraph (a) of this section, the State is entitled upon request to reconsideration of the disallowance under 45 CFR Part 16.

(43 FR 45233, Sept. 29, 1978, as amended at 51 FR 21558, June 13, 1986; 53 FR 20495, June 3, 1988; 53 FR 23101, June 17, 1988)

**Effective Date Note:** At 53 FR 20495, June 3, 1988, § 442.30 paragraph (a)(1) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.30 Agreement as evidence of certification.

- (a) . . .
- (1) The survey agency failed to apply the applicable certification standards required under Subpart D, E, F, or G of this part.

§ 442.40 Availability of FFP during appeals.

(a) **Definitions.** As used in this section—

**Effective date of expiration** means the date of expiration originally speci-

fied in the provider agreement, or the later date specified if the agreement is extended under § 442.16; and

**Effective date of termination** means a date earlier than the expiration date, set by the Medicaid agency when continuing participation until the expiration date is not justified, because the facility no longer meets the requirements for participation.

(b) **Scope, applicability, and effective date.**—(1) **Scope.** This section sets forth the extent of FFP in State Medicaid payments to a SNF or ICF after its provider agreement has been terminated or has expired and not been renewed.

(2) **Applicability.** (i) This section and § 442.42 apply only when the Medicaid agency, of its own volition, terminates or does not renew a provider agreement, and only when the survey agency certifies that there is no jeopardy to recipient health and safety. When the survey agency certifies that there is jeopardy to recipient health and safety, or when it fails to certify that there is no jeopardy, FFP ends on the effective date of termination or expiration.

(ii) When the State acts under instructions from HCFA, FFP ends on the date specified by HCFA (HCFA instructs the State to terminate the Medicaid provider agreement when HCFA (A) terminates the Medicare provider agreement with a SNF, or (B) in validating a State survey agency certification, determines that a SNF or ICF does not meet the requirements for participation.)

(3) **Effective date.** This section and § 442.42 apply to terminations or expirations that are effective on or after September 28, 1987. For terminations or nonrenewals that were effective before that date, FFP may continue for up to 120 days from September 28, 1987, or 12 months from the effective date of termination or nonrenewal, whichever is earlier.

(c) **Basic rules.** (1) Except as provided in paragraphs (d) and (e) of this section, FFP in payments to a SNF or ICF ends on the effective date of termination of the facility's provider agreement, or if the agreement is not terminated, on the effective date of expiration.

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(2) If State law, or a Federal or State court order or injunction, requires the agency to extend the provider agreement or continue payments to a facility after the dates specified in paragraph (d) of this section, FFP is not available in those payments.

(d) *Exception: Continuation of FFP after termination or expiration of provider agreement.*—(1) Conditions for continuation. FFP is available after the effective date of termination or expiration only if—

(i) The evidentiary hearing required under § 431.153 of this chapter is provided by the State agency after the effective date of termination or expiration (or, if begun before termination or expiration, is not completed until after that date); and

(ii) Termination or nonrenewal action is based on a survey agency certification that there is no jeopardy to recipients' health and safety.

(2) *Extent of continuation.* FFP is available only through the earlier of the following:

(i) The date of issuance of an administrative hearing decision that upholds the agency's termination or nonrenewal action.

(ii) The 120th day after the effective date of termination of the facility's provider agreement or, if the agreement is not terminated, the 120th day after the effective date of expiration. (If a hearing decision that upholds the facility is issued after the end of the 120-day period, when FFP has already been discontinued, the rules of § 442.42 on retroactive agreements apply).

(c) *Applicability of § 441.11.* If FFP is continued during appeal under paragraph (d) of this section, the 30-day period provided by § 441.11 of this chapter would not begin to run until issuance of a hearing decision that upholds the agency's termination or nonrenewal action.

[52 FR 32551, Aug. 28, 1987]

§ 442.42 FFP under a retroactive provider agreement following appeal.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, if a SNF or ICF is upheld on appeal from termination or nonrenewal of a provider agreement, and the State issues a ret-

roactive agreement, FFP is available beginning with the retroactive effective date, which must be determined in accordance with § 442.13.

(b) *Exception.* This rule does not apply if HCFA determines, under § 442.30, that the agreement is not valid evidence that the facility meets the requirements for participation. This exclusion applies even if the State issues the new agreement as the result of an administrative hearing decision favorable to the facility or under a Federal or State court order.

[52 FR 32551, Aug. 28, 1987]

Subpart C—Certification of SNFs, ICFs, and ICFs/MR

§ 442.100 State plan requirements.

A State plan must provide that the requirements of this subpart and Part 483 are met.

[53 FR 20495, June 3, 1988]

*EFFECTIVE DATE NOTE:* At 53 FR 20495, June 3, 1988, § 442.100 was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.100 State plan requirements.

A State plan must provide that the requirements of this subpart are met.

§ 442.101 Obtaining certification.

(a) This section states the requirements for obtaining notice of a facility's certification before a Medicaid agency executes a provider agreement under § 442.12.

(b) The agency must obtain notice of certification from the Secretary for—

(1) A facility located on an Indian reservation; and

(2) A SNF that has been certified for Medicare payments.

(c) The agency must obtain notice of certification from the survey agency for all other facilities.

(d) The notice must indicate that one of the following provisions pertains to the facility:

(1) The facility meets the applicable requirements:

(i) An SNF meets the requirements in Subpart D of this part and each of the conditions of participation in Part 405, Subpart K of this chapter.

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(ii) An ICF meets the requirements in Subparts E and F of this part.

(iii) An ICF/MR meets the requirements of Subpart E of this part and each of the conditions of participation in Part 483, Subpart D of this chapter.

(2) The facility is considered to meet applicable requirements based on waivers or variances granted by HCFA or the survey agency if such waivers or variances are allowed under the applicable subpart.

(3) The facility has been certified with deficiencies in accordance with the following:

(i) An ICF has been certified if deficiencies are covered by an acceptable plan of correction.

(ii) An SNF or ICF/MR has been certified with standard-level deficiencies if--

(A) All conditions of participation are found met; and

(B) The facility submits an acceptable plan of correction covering the remaining deficiencies, subject to other limitations specified in § 442.105.

(c) For SNFs and ICFs/MR, the failure to meet one or more of the applicable conditions of participation is cause for termination or non-renewal of the provider agreement.

[43 FR 45233, Sept. 29, 1978, as amended at 83 FR 20495, June 3, 1988]

**EFFECTIVE DATE NOTE:** At 83 FR 20495, June 3, 1988, § 442.101 (d) and (e) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.101 Obtaining certification.

(d) The notice must state that the facility--

(1) Meets the applicable requirements under Subpart D, E, F, or G of this part, except for waivers or variations granted by the Secretary or the survey agency under those subparts; or

(2) Has been certified with provision for correcting deficiencies in meeting those requirements, under the conditions of this subpart.

(e) For purposes of certification of facilities under this subpart, a waiver of standards is not a deficiency.

§ 442.105 Certification with standard-level deficiencies: General provisions.

If a survey agency finds a facility deficient in meeting the standards specified under Subpart D, E or F of this part or under Subpart D of Part 483, the agency may certify the facility for Medicaid purposes under the following conditions:

(a) The agency finds that the facility's deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care. The agency must maintain a written justification of these findings.

(b) The agency finds acceptable the facility's written plan for correcting the deficiencies.

(c) If a facility was previously certified with a deficiency and has a different deficiency at the time of the next survey, the agency documents that the facility--

(1) Was unable to stay in compliance with the standard for reasons beyond its control, or despite intensive efforts to comply; and

(2) Is making the best use of its resources to furnish adequate care.

(d) If a facility has the same deficiency it had under the prior certification, the agency documents that the facility--

(1) Did achieve compliance with the standard at some time during the prior certification period;

(2) Made a good faith effort, as judged by the survey agency, to stay in compliance; and

(3) Again became out of compliance for reasons beyond its control.

(e) If an ICF or ICF/MR has a deficiency of the types specified in § 442.111 or § 442.112 that requires a plan of correction extending beyond 12 months, the agency documents that the conditions of those sections are met.

[43 FR 45233, Sept. 29, 1978, as amended at 83 FR 20496, June 3, 1988]

**EFFECTIVE DATE NOTE:** At 83 FR 20496, June 3, 1988, § 442.105, was amended by revising the title and the introductory paragraph, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

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§ 442.105 Certification with deficiencies: General provisions.

If survey agency finds a facility deficient in meeting the standards specified under Subpart D, E, F, or G of this part, the agency may certify the facility for Medicaid purposes under the following conditions:

§ 442.109 Certification period: General provisions.

(a) A survey agency may certify a facility that fully meets applicable requirements for up to 12 months.

(b) The survey agency may notify the Medicaid agency that the term of a provider agreement may be extended up to 2 months after the expiration date of the agreement under the conditions specified in § 442.16.

143 FR 45233, Sept. 29, 1978 Redesignated at 53 FR 1993, Jan. 25, 1988

§ 442.110 Certification period: Facilities with standard-level deficiencies.

(a) Facilities with deficiencies may be certified under § 442.105 for the period specified in either paragraph (b) or (c) of this section. However, ICF's with deficiencies that may require more than 12 months to correct may be certified under §§ 442.111 and 442.112.

(b) The survey agency may certify a facility for a period that ends no later than 60 days after the last day specified in the plan for correcting deficiencies. The certification period must not exceed 12 months, including the period allowed for corrections.

(c) The survey agency may certify a facility for up to 12 months with a condition that the certification will be automatically canceled on a specified date within the certification period unless—

(1) The survey agency finds that all deficiencies have been satisfactorily corrected; or

(2) The survey agency finds and notifies the Medicaid agency that the facility has made substantial progress in correcting the deficiencies and has a new plan for correction that is acceptable.

The automatic cancellation date must be no later than 60 days after the last

day specified in the plan for correction of deficiencies under § 442.105.

143 FR 45233, Sept. 29, 1978. Redesignated and amended at 53 FR 1993, Jan. 25, 1988; 53 FR 20496, June 3, 1988

Effective Date Note: At 53 FR 20496, June 3, 1988, in § 442.110, the heading was revised, by inserting the words "standard-level" between "with" and "deficiencies", effective October 3, 1988.

§ 442.111 Extended period for correcting deficiencies: ICF's other than ICF's/MR; environment, sanitation and Life Safety Code deficiencies.

(a) Scope. This section applies to ICF's other than ICF's/MR that are deficient in meeting requirements for—

(1) Environment and sanitation (§§ 442.324 through 442.330); or

(2) Life Safety Code (§§ 442.321 through 442.323).

(b) Certification period. The survey agency may certify an ICF other than an ICF/MR under § 442.105 for up to 12 months even though the facility has deficiencies that may take up to 2 years after the first certification of the facility to correct, if the conditions in this section are met.

(c) Written plan for correction. The ICF must submit a written plan for correcting the deficiencies that—

(1) Specifies the steps the facility will take to correct each deficiency;

(2) Specifies a timetable for taking each of those steps and a date for completion of correction of each deficiency that is not later than 2 years after the date the facility is first certified; and

(3) Is acceptable to the survey agency.

(d) Feasibility of plan. The survey agency must find that the facility can—

(1) Potentially meet the requirements in which it is deficient by taking the steps specified in the plan for correction; and

(2) Correct each deficiency by the date specified in the plan for correction.

(e) Progress in meeting correction plan. Within each 6-month period after acceptance of the plan for correction, the survey agency must find,

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and record in the survey record, that the facility has made substantial progress in meeting its plan for correction. These findings must be based on onsite surveys by qualified surveyors. The survey agency must support these findings by placing signed contracts, work orders, or other documents in the survey record.

(f) *State fire safety and sanitation requirements.* The survey agency must find that, during the period allowed for corrections, the facility meets State fire safety and sanitation codes and regulations.

[43 FR 45233, Sept. 29, 1978. Redesignated and amended at 53 FR 1993, Jan. 25, 1988]

§ 442.112 Extended period for correcting deficiencies: ICFs/MR: Life Safety Code and living/dining/therapy area deficiencies.

(a) *Scope.* This section applies to ICFs/MR that are deficient in meeting requirements for—

(1) Life Safety Code (§§ 442.507-442.508);

(2) Living units (§§ 442.447(a) (1), (2), (4), (5), (b), (c), 442.448(d), 442.449 (a), (b), 442.450(a)(2), 442.451(a), 442.452, 442.453);

(3) Dining rooms (§ 442.471(a)-(c));

or

(4) Therapy areas (§ 442.488(e)).

(b) *Certification period.* The survey agency may certify an ICF/MR under § 442.105 for up to 12 months even though the deficiencies listed in paragraph (a) of this section may take more than 12 months to correct, if the conditions in this section and § 442.115 are met.

(c) *Written plan for correction.* Before certifying an ICF/MR under this section, the survey agency must approve, in writing, the ICF/MR's written plan for correcting those deficiencies. The plan must—

(1) State the extent to which the ICF/MR complies with the requirements it does not fully meet;

(2) Specify the steps the ICF/MR will take to correct the deficiencies;

(3) Specify a timetable for taking each of those steps and a date for completion of corrections;

(4) For a public ICF/MR, be approved by the State or political subdivision that has jurisdiction over its op-

eration (A public facility is defined in § 435.1009 of this subchapter as one that is the "responsibility of a governmental unit or over which a governmental unit exercises administrative control."); and

(5) Meet the conditions of § 442.113.

(d) *Progress in meeting correction plan.* Within each 6-month period after initial approval of the plan, the survey agency must find, and record in the survey record, that the ICF/MR has made substantial progress in meeting the plan for correction. These findings must be based on onsite surveys by qualified surveyors. The survey agency must support these findings by placing signed contracts, work orders, or other documentation in the survey record.

(e) *State fire safety and sanitation requirements.* The survey agency must find that, during the period allowed for corrections, the ICF/MR meets the State fire safety and sanitation codes and regulations.

[43 FR 45233, Sept. 29, 1978. Redesignated and amended at 53 FR 1993 and 1994, Jan. 25, 1988]

§ 442.113 Correction plans for ICFs/MR: Life Safety Code and living/dining/therapy area deficiencies.

(a) The ICF/MR's plan required by § 442.112 must provide for completion of corrections by:

(1) July 18, 1980; or

(2) July 18, 1982, if authorized by HCFA under paragraph (b) or (e) of this section; or

(3) the date approved by HCFA, if authorized by HCFA under paragraph (f) of this section; or

(4) the date approved by HCFA, if authorized by HCFA under paragraph (g) of this section, when corrections of deficiencies in units to be retained are completed within the appropriate time period as set forth in paragraph (g) of this section.

(b) If, at the time of the first survey of the ICF/MR after July 17, 1977, it is unable to develop a plan to complete corrections by July 18, 1980, the survey agency may request HCFA to authorize approval of a plan to complete them by July 18, 1982. HCFA will authorize this approval for each

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deficiency if it is determined that time beyond July 18, 1977, is needed—

(1) As a practical matter to complete the corrections;

(2) To prevent unreasonable hardship to the ICF/MR; and

(3) To insure continued care for recipients served by the ICF/MR.

(c) If the plan provides for correction through structural change or renovation, it must—

(1) Contain a timetable showing the corrective steps and their completion dates;

(2) Specify the structural change or renovation; and

(3) Document that sufficient financial resources are available to complete the change or renovation on schedule.

(d) If the plan provides for correction by phasing out part or all of the ICF/MR, it must—

(1) Contain a timetable showing the buildings or units to be closed and describing the steps for phasing them out;

(2) Describe the methods that insure the recipients' health and safety until the building or unit is closed; and

(3) Provide that no new recipients will be admitted to the building or unit after the plan has been approved.

(e) If an ICF/MR is unable to complete corrections required by the plan of correction by July 18, 1980 and it did not request an extension beyond that date under paragraph (b) of this section, the survey agency may request HCFA to authorize approval for an extension of the facility's plan of correction to July 18, 1982 if—

(1) For corrections under paragraph (c) of this section, the facility provides documentation from the renovation project's supervising architect or contractor that required construction work was at least 25 percent completed by July 18, 1980 and will be completed by July 18, 1982;

(2) For corrections under paragraph (d) of this section, the facility provides documentation that the phase out program was at least 25 percent completed on July 18, 1980 and will be completed by July 18, 1982; and

(3) The survey agency finds that all continuing deficiencies covered by the plan of correction will be resolved by

completion of the construction, renovation, or phase out of beds.

(f) If an ICF/MR is unable to complete corrections required by the plan of correction by July 18, 1980 or July 18, 1982, as authorized in paragraphs (a), (b) and (e) of this section, the survey agency may request HCFA to authorize a plan of correction for an additional period of time if the delay was caused by litigation, provided that—

(1) The United States, or any agency or Department thereof, was party to the litigation, or was an intervenor in it, or participated as an amicus curiae; and

(2) The United States advocated a position which caused or contributed, in whole or in part, to the delay; and

(3) The request for an additional period of time to complete corrections under this provision does not exceed the amount of the delay resulting from the litigation, as determined by HCFA.

(g) The survey agency may request HCFA by November 24, 1982 to approve a revision to the existing correction plan of an ICF/MR under this section if the facility chooses to engage in a partial or complete phase out of beds in certified units of the facility already contained in the present correction plan as follows:

(1) The extended phase out period to be approved by HCFA may be 1 to 5 years from August 26, 1982 if the facility:

(i) Provides documentation that it has completed at least 25 percent of the items in the original correction plans under paragraphs (c) and (d) of this section;

(ii) Increases the total number of beds being phased out within certified units;

(iii) Agrees to a rate of decline in resident population, and establishes, in the revised correction plan submitted under this paragraph, targets at six-month intervals for the phasing out of a specific number of beds;

(iv) Assures the health and safety of the residents until the buildings or units are phased out; and

(v) Ensures that only residents who are classified for the ICF/MR level of care when the revised correction plan

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submitted under this paragraph is approved, will be admitted thereafter to the buildings or units being phased out.

(2) The survey agency must ensure that the facility has met all the facility standards for ICFs/MR (Subpart G of this part), or has an approved plan of correction for those certified buildings and units in use and to be retained after the phase out plan is completed; and

(3) The facility may not seek certification of units not currently certified in order to add the beds in those units to an expanded phase out plan as a means of taking advantage of this regulation.

(4) FFP will not be available for costs attributable to any beds which remain above the targeted phase out goals after each 6-month target date is passed.

(Secs. 1102, 1905(c) and 1905(d) of the Social Security Act (42 U.S.C. 1302, 1396d(c), 1396d))

[47 FR 37549, Aug. 26, 1982. Redesignated and amended at 53 FR 1993 and 1994, Jan. 25, 1988]

§ 442.114 Correction and reduction plans for ICFs/MR: General provisions.

(a) *Options of Medicaid agency.* If HCFA finds substantial deficiencies only in physical plant and staffing that do not pose an immediate threat to the clients' health and safety in an ICF/MR, HCFA will forward the list of deficiencies to the Medicaid agency and the agency may elect to—

(1) Submit to HCFA within 30 days of receipt of the list of deficiencies a written plan of correction in accordance with § 442.115, as permitted by § 442.105; or

(2) Submit to HCFA within 65 days of receipt of the list of deficiencies a written plan to reduce permanently the number of beds in certified units in accordance with § 442.116. The purpose of the reduction plan is to vacate any noncomplying buildings (or distinct parts thereof) and correct any staff deficiencies within 36 months of the approval of the plan.

(b) *Option limitation for Medicaid agency.* An ICF/MR found to have substantial deficiencies in physical plant and staffing, and substantial de-

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ficiencies in other areas of care is not eligible for either a correction or reduction plan under this section.

(c) *HCFA options.* (1) If the Medicaid agency does not comply with paragraph (a) of this section, HCFA may cancel approval of the deficient ICF/MR's participation in the Medicaid program in accordance with section 1910(c) of the Act.

(2) HCFA will respond in writing to the agency within 30 days from receipt of a proposed correction plan submitted under paragraph (a)(1) of this section.

(d) *Duration.* The provisions of this section and §§ 442.115 and 442.116 apply only to correction and reduction plans approved by HCFA within 3 years after Federal surveys initiated in ICF/MRs on or after April 7, 1986.

[53 FR 1994, Jan. 25, 1988]

§ 442.115 Correction plans for ICFs/MR: Specific requirements.

(a) *Contents.* A correction plan under § 442.114(a)(1) must include—

(1) An explanation of the extent to which the ICF/MR currently complies with the standards for ICFs/MR in Subpart G including all deficiencies identified during a direct Federal survey, and

(2) A timetable for completing the necessary steps to correct staff and physical plant deficiencies on which the request for a correction plan is based, and all other minor deficiencies, within 6 months of the approval date of the plan.

(b) *HCFA policies.* HCFA considers a correction plan only if HCFA received it within 30 days of receipt by the Medicaid agency of the list of deficiencies referred to in § 442.114(a). After consideration of the plan, HCFA will forward in writing its approval or disapproval within 30 days of receipt of the proposed correction plan.

(c) *Exception.* If, as a result of a public hearing, the Medicaid agency decides that a reduction plan is not appropriate, and instead decides to submit a correction plan, the correction plan must be received by HCFA within 30 days from the date of the public hearing.

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(d) *Termination of an ICF/MR.* (1) If the Medicaid agency submits a correction plan that HCFA finds to be unacceptable, HCFA will notify the agency of its disapproval and will terminate the ICF/MR's participation in the Medicaid program in accordance with section 1910(c) of the Act.

(2) If, at the conclusion of the 6-month period specified in the plan of correction described in paragraph (a) of this section, HCFA determines that the agency has substantially failed to correct the deficiencies identified, HCFA may terminate the ICF/MR from participating in the Medicaid program in accordance with section 1910(c) of the Act.

(53 FR 1994, Jan. 25, 1988)

§ 442.116 Reduction plans for ICFs/MR. Specific requirements.

(a) *Conditions of approval: Agency requirements.* Before submitting a reduction plan under § 442.116(a)(2) to HCFA, the Medicaid agency must—

(1) Conduct a public hearing at the affected ICF/MR at least 35 days before submitting the reduction plan to HCFA that outlines the—

(i) Contents of the reduction plan,  
(ii) Process for submitting the plan to HCFA, and

(iii) Process for submitting public comments to HCFA within 30 days of receipt of the reduction plan by HCFA.

(2) Provide written notice of the hearing to staff, clients and their parents or guardians, and the nearest, most interested, or involved family member or party, as appropriate, at least 10 days prior to the hearing date.

(3) Announce to advocacy and other interested groups and agencies; the courts with which the ICF/MR is involved in litigation (if any) arising out of its Medicaid participation; and the general community; through local media notices, at least 10 days prior to the hearing date—

(i) The exact date, time and location of the hearing; and

(ii) The locations (that is, the affected ICF/MR, the State mental retardation administration, State survey agency, State Developmental Disabilities Council, State and local protection and advocacy agencies and other

agencies, which in the State's judgment, serve potentially interested parties (for example, State and local associations for retarded citizens)) where the proposed plan is displayed.

(4) Demonstrate that it has successfully provided home and community services similar to those services proposed to be provided under the reduction plan for similar individuals eligible for Medicaid by including—

(i) Documentation of existing programs and level of funding, and

(ii) Projections for growth and how the growth will be funded to accommodate the clients being displaced by the reduction plan.

(5) Provide assurances to HCFA that the reduction plan will be completed by fulfilling the content requirements of the reduction plan contained in paragraph (d) of this section.

(b) *Withdrawal by a Medicaid agency of a proposed reduction plan.* If, after the public hearing, a Medicaid agency decides a reduction plan would not be appropriate, the agency may choose to proceed with a plan of correction in accordance with the requirements contained in §§ 442.115 (a) and (c).

(c) *Submission date of plan.* On the day that the Medicaid agency submits a reduction plan, the agency must announce through local media notices—

(1) That the plan has been submitted to HCFA;

(2) That the plan is on display at the affected ICF/MR, the State mental retardation administration, State survey agency, State Developmental Disabilities Council, State and local protection and advocacy agencies, and other agencies, which in the State's judgment, serve potentially interested parties (for example, State and local associations for retarded citizens); and

(3) The address of the appropriate HCFA office for forwarding comments on the reduction plan and the closing date for receipt of those comments.

(d) *Contents.* A reduction plan must—

(1) Identify the number of clients and their service needs on a client-by-client basis for home or community services, and a timetable for providing such services, in 6-month intervals, within the 36-month period beginning

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on the date that the reduction plan is approved by HCFA:

(2) Describe the methods used to—  
(i) Select clients for home or community services, and

(ii) Develop alternative home and community services to effectively meet the clients' needs;

(3) Describe the safeguards that will be applied to protect the clients' health and welfare while receiving home or community services, including—

(i) Adequate standards for participation by clients, clients' families and providers; and

(ii) Assurances that the community residences in which the affected clients are placed meet all applicable State and Federal licensure and certification requirements;

(4) Provide that clients who are eligible for medical assistance while in the ICF/MR will, at their option, be placed in another setting (or another part of the ICF/MR) so as to retain their eligibility for medical assistance.

(5) Specify the actions to protect the health and safety of the clients remaining in the ICF/MR while the reduction plan is in effect;

(6) Provide that the staff-to-client ratio at the ICF/MR will be the higher of—

(i) The ratio described in the standards for ICFs and ICFs/MR (§ 442.445); or

(ii) The ratio which was in effect at the time the direct Federal survey was conducted; and

(7) Provide for the protection of the staff affected by the reduction plan, including—

(i) Arrangements to preserve staff rights and benefits;

(ii) Training and retraining of staff where necessary;

(iii) Redeploying staff to community settings under the reduction plan; and

(iv) Making maximum efforts to secure employment (without necessarily guaranteeing the employment of any staff).

(e) *HCFA policies.* (1) HCFA will consider approval of reduction plans on a first come, first served basis. HCFA will provide the public at least 30 days after the Medicaid agency submits a reduction plan to comment on

the proposed plan. After the close of the public comment period, HCFA will forward in writing its approval or disapproval of the reduction plan to the agency within 30 days.

(2) If HCFA approves more than 15 reduction plans in any fiscal year, any reduction plans approved in addition to the first 15 approved plans, will be for an ICF/MR (or distinct part thereof) for which the costs of correcting the substantial deficiencies are \$2 million or greater (as demonstrated by the Medicaid agency to the satisfaction of HCFA).

(3) HCFA may approve reduction plans for a shorter period than 36 months, where applicable.

(4) HCFA approval of a reduction plan does not constitute approval of any request for a home and community-based waiver. Home and community-based waivers are subject to HCFA review and approval under § 441.300 of this chapter. Disapproval of a request for a home and community-based waiver constitutes disapproval of a request for a reduction plan that is dependent upon approval of the request for a home and community-based waiver.

(f) *Termination of an ICF/MR.* (1) If the Medicaid agency submits a reduction plan that HCFA finds to be unacceptable, HCFA will notify the agency of its disapproval and terminate the ICF/MR's participation in the Medicaid program in accordance with section 1910(c) of the Act.

(2) If, at the conclusion of the initial 6-month period or any 6-month interval thereafter of the reduction plan, HCFA determines that the Medicaid agency has substantially failed to meet the requirements of paragraph (a) of this section, HCFA will—

(i) Terminate the ICF/MR from participating in the Medicaid program in accordance with section 1910(c) of the Act, or

(ii) Disallow FFP equal to 5 percent of the cost of care for all eligible clients for each month for which the agency failed to meet the requirements despite good faith efforts it may have made.

[53 FR 1994, Jan. 25, 1988]

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§ 442.117 Termination of certification for facilities whose deficiencies pose immediate jeopardy.

(a) A survey agency must terminate a facility's certification if it determines that—

(1) The facility no longer meets applicable conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs) specified under Subpart D, E, and F of this part or Part 483, Subpart D of this chapter; and

(2) The facility's deficiencies pose immediate jeopardy to patients' health and safety.

(b) Subsequent to a certification of a facility's noncompliance, the Medicaid agency must, in terminating the provider agreement, follow the appeals process specified in Part 431, Subpart D of this chapter.

[51 FR 24491, July 3, 1986, as amended at 53 FR 20496, June 3, 1988]

**EFFECTIVE DATE NOTE:** At 53 FR 20496, June 3, 1988, in § 442.117, paragraph (a) (1) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.117 Termination of certification for facilities whose deficiencies pose immediate jeopardy.

(a) \* \* \*

(1) The facility no longer meets applicable conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR) specified under Subpart D, E, F, or G of this part, and

§ 442.118 Denial of payments for new admissions.

(a) **Basis for denial of payments.** The Medicaid agency may deny payment for new admissions to a SNF, ICF, or ICF/MR that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR) specified under Subpart D, E, F, or G of this part if either of the following conditions is met:

(1) *Facility's deficiencies do not pose immediate jeopardy.* If the agency finds that the facility's deficiencies do not pose immediate jeopardy to patients' health and safety, the agency may either terminate the facility's

provider agreement or deny payment for new admissions.

(2) *Facility's deficiencies do pose immediate jeopardy.* If the agency finds that the facility's deficiencies do pose immediate jeopardy to patients' health and safety and thereby terminates the facility's provider agreement, the agency may additionally seek to impose the denial of payment sanction.

(b) **Agency procedures.** Before denying payments for new admissions, the Medicaid agency must comply with the following requirements:

(1) Provide the facility up to 60 days to correct the cited deficiencies and comply with the conditions (for SNFs and ICFs/MR) or the standards (for ICFs).

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the applicable conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs) participation; and

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

(c) **Effect of denial of Medicare payment—**(1) *Period of denial.* If HCFA denies Medicare payments for new admissions to a SNF that also participates in Medicaid, the Medicaid agency must deny Medicaid payments for new admissions, effective for the same time period that Medicare payments are denied.

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(2) *Informal hearing.* Only one informal hearing is available to a SNF that participates in both programs. It would be provided by HCFA in accordance with § 489.62(c) of this chapter.

ards (for ICFs and ICFs/MR)" and adding in its place the phrase "conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs)", effective October 3, 1988.

(51 FR 24491, July 3, 1986, as amended at 53 FR 20496, June 3, 1988)

**EFFECTIVE DATE NOTE:** At 53 FR 20496, June 3, 1988, § 442.119 (b)(1) and (b)(3)(i) was amended, effective October 3, 1988. Paragraph (b)(1) was amended by adding the phrase "ICFs/MR" after "SNFs", and paragraph (b)(3)(i) was amended by removing the phrase "conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR)" and adding in its place the phrase "conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs)."

§ 442.119 Duration of denial of payments and subsequent termination.

(a) *Period of denial.* The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the Medicaid agency finds that—

(1) The facility has corrected the deficiencies or is making a good faith effort to achieve compliance with the conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs); or

(2) The deficiencies are such that it is necessary to terminate the facility's provider agreement.

(b) *Subsequent termination.* The Medicaid agency must terminate a facility's provider agreement—

(1) Upon the agency's finding that the facility has been unable to achieve compliance with the conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs) during the period that payments for new admissions have been denied;

(2) Effective the day following the last day of the denial of payments period; and

(3) In accordance with the procedures for appeal of terminations set forth in Subpart D of Part 431 of this chapter.

(51 FR 24491, July 3, 1986, as amended at 53 FR 20496, June 3, 1988)

**EFFECTIVE DATE NOTE:** At 53 FR 20496, June 3, 1988, § 442.119(a)(1) and (b)(1) were amended by removing the phrase "conditions of participation (for SNFs) or stand-

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Subpart E—Intermediate Care Facility Requirements; All Facilities

§ 442.250 Purpose.

This subpart specifies the requirements that an ICF must meet to obtain certification from the State survey agency as a qualified provider of ICF services.

§ 442.251 State licensing standards.

(a) Except as provided in paragraph (b) of this section, an ICF must meet standards for a State license to provide, on a regular basis, health-related care and services to individuals who do not require hospital or SNF care, but whose mental or physical condition requires services—

- (1) Above the level of room and board; and
- (2) That can be provided only by an institution.

(b) An ICF that formerly met State licensing standards but does not currently meet them may continue to receive Medicaid payments as a qualified provider during a period specified by the State authority responsible for licensing the facility if, during that period, the ICF takes the steps needed to again meet the standards.

(c) An ICF operated by a government agency must meet the licensing standards that apply to the same type of facility operated under any other ownership.

(d) In accordance with § 431.110 of this subchapter, an Indian Health Service ICF must meet State licensing standards although it need not obtain a license. In making this determination, the licensing authority may not take into account an absence of licensure of any staff member of the facility.

§ 442.252 State safety and sanitation standards.

An ICF must meet State safety and sanitation standards for nursing homes.

Effective Date Note: At 53 FR 20496, June 3, 1988, § 442.252 was removed, effective Oct. 3, 1988.

§ 442.253 Federal definition and standards.

(a) An ICF other than an ICF/MR must meet the definition in § 440.150 of this subchapter and the standards specified in this subpart and Subpart F of this part, except for provisions waived or accepted under plans of corrections as specified in Subpart C of this part.

(b) An ICF/MR must meet the definition in § 440.150 of this subchapter and the standards specified in this subpart and Subpart G of this part, except for provisions waived or accepted under plans of correction as specified in Subpart C of this part.

§ 442.254 Standards for hospitals and SNF's providing ICF services.

(a) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF services other than ICF/MR services, it must meet the following ICF standards:

- (1) Section 442.304, resident services director.
- (2) Section 442.317 (a), (b), agreements with outside resources for institutional services.
- (3) Section 442.319, plan of care.
- (4) Section 442.320, resident financial records.
- (5) Section 442.324 (b), handrails.
- (6) Section 442.338 through 442.342, health services.
- (7) Section 442.343, rehabilitative services.
- (8) Section 442.344, social services.
- (9) Section 442.345, activities program.
- (10) Section 442.346, physician services.

(b) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF/MR services, it must meet each of the conditions of participation specified in Part 483, Subpart D of this chapter.

(43 FR 45233, Sept. 29, 1978, as amended at 53 FR 20496, June 3, 1988)

Effective Date Note: At 53 FR 20496, June 3, 1988, § 442.254 (b) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

§ 442.254 Standards for hospitals and SNF's providing ICF services.

(b) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF/MR services, it must meet the standards in Subpart G of this part.

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**PART 483—CONDITIONS OF PARTICIPATION FOR LONG TERM CARE FACILITIES**

Subpart A-C—(Reserved)

Subpart D—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

Sec.

- 483.400 Basis and purpose.
- 483.405 Relationship to other HHS regulations.
- 483.410 Condition of participation: Governing body and management.
- 483.420 Condition of participation: Client protections.
- 483.430 Condition of participation: Facility staffing.
- 483.440 Condition of participation: Active treatment services.
- 483.450 Condition of participation: Client behavior and facility practices.
- 483.460 Condition of participation: Health care services.
- 483.470 Condition of participation: Physical environment.
- 483.480 Condition of participation: Dietetic services.

**AUTHORITY:** Secs. 1102, 1905(c) and (d) of the Social Security Act (42 U.S.C. 1302, 1396d(c) and (d)).

**SOURCE:** 53 FR 20496, June 3, 1988, unless otherwise noted.

**EFFECTIVE DATE NOTE:** At 53 FR 20496, June 3, 1988, Part 483 was added, effective October 3, 1988.

Subpart A-C—(Reserved)

Subpart D—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

§ 483.400 Basis and purpose.

This subpart implements section 1905 (c) and (d) of the Act which gives the Secretary authority to prescribe regulations for intermediate care facility services in facilities for the mentally retarded or persons with related conditions.

§ 483.405 Relationship to other HHS regulations.

In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the appli-

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cable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR Part 80), nondiscrimination on the basis of handicap (45 CFR Part 84), nondiscrimination on the basis of age (45 CFR Part 91), protection of human subjects of research (45 CFR Part 46), and fraud and abuse (42 CFR Part 455). Although those regulations are not in themselves considered conditions of participation under this Part, their violation may result in the termination or suspension of, or the refusal to grant or continue, Federal financial assistance.

§ 483.410 Condition of participation: Governing body and management.

(a) **Standard: Governing body.** The facility must identify an individual or individuals to constitute the governing body of the facility. The governing body must—

(1) Exercise general policy, budget, and operating direction over the facility;

(2) Set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility; and

(3) Appoint the administrator of the facility.

(b) **Standard: Compliance with Federal, State, and local laws.** The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to health, safety, and sanitation.

(c) **Standard: Client records.**

(1) The facility must develop and maintain a recordkeeping system that includes a separate record for each client and that documents the client's health care, active treatment, social information, and protection of the client's rights.

(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.

(d) **Standard: Services provided under agreements with outside sources.**

(1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement must—

(i) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and

(ii) Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.

(3) The facility must assure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in § 483.470 (a) through (g), (j) and (k).

§ 483.420 Condition of participation: Client protections.

(a) **Standard: Protection of clients' rights.** The facility must ensure the rights of all clients. Therefore, the facility must—

(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of

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the United States, including the right to file complaints, and the right to due process;

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs;

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail;

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in his or her own clothing each day; and

(13) Permit a husband and wife who both reside in the facility to share a room.

(b) *Standard: Client finances.* (1) The facility must establish and maintain a system that—

(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) *Standard: Communication with clients, parents, and guardians.* The facility must—

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients' families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

(d) *Standard: Staff treatment of clients.* (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or

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abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

§ 483.430 Condition of participation: Facility staffing.

(a) *Standard: Qualified mental retardation professional.* Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who—

(1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and

(2) Is one of the following:

(i) A doctor of medicine or osteopathy.

(ii) A registered nurse.

(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section.

(b) *Standard: Professional program services.* (1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff must work directly with clients and with paraprofessional, non-professional and other professional program staff who work with clients.

(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and non-professional staff members.

(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in § 483.410(b), must meet the following qualifications:

(i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.

(v) To be designated as a psychologist, an individual must have at least a master's degree in psychology from an accredited school.

(vi) To be designated as a social worker, an individual must—

(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or

(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

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(vii) To be designated as a speech-language pathologist or audiologist, an individual must—

(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or

(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

(viii) To be designated as a professional recreation staff member, an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.

(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

(xi) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5) (i) through (x) of this section are not required—

(A) Except for qualified mental retardation professionals;

(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and

(C) Unless otherwise specified by State licensure and certification requirements.

(c) *Standard: Facility staffing.* (1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing—

(i) Clients for whom a physician has ordered a medical care plan;

(ii) Clients who are aggressive, assaultive or security risks;

(iii) More than 16 clients; or

(iv) Fewer than 16 clients within a multi-unit building.

(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing—

(i) Clients for whom a physician has not ordered a medical care plan;

(ii) Clients who are not aggressive, assaultive or security risks; and

(iii) Sixteen or fewer clients.

(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

(d) *Standard: Direct care (residential living unit) staff.* (1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:

(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2.

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4.

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

(4) When there are no clients present in the living unit, a responsi-

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ble staff member must be available by telephone.

(e) *Standard: Staff training program.* (1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

§ 483.440 Condition of participation: Active treatment services.

(a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) *Standard: Admissions, transfers, and discharge.* (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as

well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must—

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) *Standard: Individual program plan.* (1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for ex-

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ample, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must—

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

(iii) Identify the client's specific developmental and behavioral management needs;

(iv) Identify the client's need for services without regard to the actual availability of the services needed; and

(v) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives. These objectives must—

(i) Be stated separately, in terms of a single behavioral outcome;

(ii) Be assigned projected completion dates;

(iii) Be expressed in behavioral terms that provide measurable indices of performance;

(iv) Be organized to reflect a developmental progression appropriate to the individual; and

(v) Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan must specify:

(i) The methods to be used;

(ii) The schedule for use of the method;

(iii) The person responsible for the program;

(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

(v) The inappropriate client behavior(s), if applicable; and

(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan must also:

(i) Describe relevant interventions to support the individual toward independence.

(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

(iv) Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

(d) *Standard: Program implementation.* (i) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

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(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

(e) *Standard: Program documentation.* (1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

(2) The facility must document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

(f) *Standard: Program monitoring and change.* (1) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client—

(i) Has successfully completed an objective or objectives identified in the individual program plan;

(ii) Is regressing or losing skills already gained;

(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

(iv) Is being considered for training towards new objectives.

(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior,

and persons with no ownership or controlling interest in the facility to—

(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

(ii) Insure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian; and

(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes need to be addressed.

(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

§ 483.450 Condition of participation: Client behavior and facility practices.

(a) *Standard: Facility practices—Conduct toward clients.* (1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures must—

(i) Promote the growth, development and independence of the client;

(ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;

(iii) Specify client conduct to be allowed or not allowed; and

(iv) Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients must participate in the formulation of these policies and procedures.

(3) Clients must not discipline other clients, except as part of an organized

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system of self-government, as set forth in facility policy.

(b) *Standard: Management of inappropriate client behavior.* (1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures must be consistent with the provisions of paragraph (a) of this section. These procedures must—

(i) Specify all facility approved interventions to manage inappropriate client behavior;

(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

(iii) Insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

(iv) Address the following:

(A) The use of time-out rooms.

(B) The use of physical restraints.

(C) The use of drugs to manage inappropriate behavior.

(D) The application of painful or noxious stimuli.

(E) The staff members who may authorize the use of specified interventions.

(F) A mechanism for monitoring and controlling the use of such interventions.

(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with § 483.440(c) (4) and (5) of this subpart.

(5) Standing or as needed programs to control inappropriate behavior are not permitted.

(c) *Standard: Time-out rooms.* (1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)

(ii) The client is under the direct constant visual supervision of designated staff.

(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

(2) Placement of a client in a time-out room must not exceed one hour.

(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

(4) A record of time-out activities must be kept.

(d) *Standard: Physical restraints.* (1) The facility may employ physical restraint only—

(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

(ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or

(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

(2) Authorizations to use or extend restraints as an emergency must be:

(i) In effect no longer than 12 consecutive hours; and

(ii) Obtained as soon as the client is restrained or stable.

(3) The facility must not issue orders for restraint on a standing or as needed basis.

(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as

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quickly as possible, and a record of these checks and usage must be kept.  
(5) Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed, and a record of such activity must be kept.

(7) Barred enclosures must not be more than three feet in height and must not have tops.

(e) *Standard: Drug usage.* (1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.

(2) Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

(4) Drugs used for control of inappropriate behavior must be—

(i) Monitored closely, in conjunction with the physician and the drug regimen review requirement at § 483.460(j), for desired responses and adverse consequences by facility staff; and

(ii) Gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

§ 483.460 Condition of participation: Health care services.

(a) *Standard: Physician services.*

(1) The facility must ensure the availability of physician services 24 hours a day.

(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician

determines that an individual client requires 24-hour licensed nursing care. This plan must be integrated in the individual program plan.

(3) The facility must provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

(i) Evaluation of vision and hearing.

(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

(iii) Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

(iv) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.

(b) *Standard: Physician participation in the individual program plan.* A physician must participate in—

(1) The establishment of each newly admitted client's initial individual program plan as required by § 456.360 of this chapter that specified plan of care requirements for ICFs; and

(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

(c) *Standard: Nursing services.* The facility must provide clients with nursing services in accordance with their needs. These services must include—

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process;

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician

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has determined that an individual client requires such a plan;

(3) For those clients certified as not needing a medical care plan, a review of their health status which must—

(i) Be by a direct physical examination;

(ii) Be by a licensed nurse;

(iii) Be on a quarterly or more frequent basis depending on client need;

(iv) Be recorded in the client's record; and

(v) Result in any necessary action (including referral to a physician to address client health problems).

(4) Other nursing care as prescribed by the physician or as identified by client needs; and

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to—

(i) Training clients and staff as needed in appropriate health and hygiene methods;

(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and

(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

(d) *Standard: Nursing staff.* (1) Nurses providing services in the facility must have a current license to practice in the State.

(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients health needs including those clients with medical care plans.

(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.

(5) Non-licensed nursing personnel who work with clients under a medical

care plan must do so under the supervision of licensed persons.

(e) *Standard: Dental services.* (1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility must provide education and training in the maintenance of oral health.

(f) *Standard: Comprehensive dental diagnostic services.* Comprehensive dental diagnostic services include—

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility (unless the examination was completed within twelve months before admission);

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease; and

(3) A review of the results of examination and entry of the results in the client's dental record.

(g) *Standard: Comprehensive dental treatment.* The facility must ensure comprehensive dental treatment services that include—

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and

(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(h) *Standard: Documentation of dental services.* (1) If the facility maintains an in-house dental service, the facility must keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

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(2) If the facility does not maintain an in-house dental service, the facility must obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

(i) *Standard: Pharmacy services.* The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

(j) *Standard: Drug regimen review.* (1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.

(4) An individual medication administration record must be maintained for each client.

(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

(k) *Standard: Drug administration.* The facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must assure that—

(1) All drugs are administered in compliance with the physician's orders;

(2) All drugs, including those that are self-administered, are administered without error;

(3) Unlicensed personnel are allowed to administer drugs only if State law permits;

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self administration of medications is an appropriate objective, and if the physician does not specify otherwise;

(5) The client's physician is informed of the interdisciplinary team's

decision that self-administration of medications is an objective for the client;

(6) No client self-administers medications until he or she demonstrates the competency to do so;

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law; and

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

(l) *Standard: Drug storage and recordkeeping.* (1) The facility must store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self administer drugs in accordance with § 483.460(k)(4) may have access to keys to their individual drug supply.

(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. § 801 et seq., as implemented by 21 CFR Part 308).

(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs.

(m) *Standard: Drug labeling.* (1) Labeling of drugs and biologicals must—

(i) Be based on currently accepted professional principles and practices; and

(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility must remove from use—

(i) Outdated drugs; and

(ii) Drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately re-

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moved from the client's current medication supply if discontinued by the physician.

(n) *Standard: Laboratory services.* (1) For purposes of this section, "laboratory" means an entity for the microbiological, serological, chemical, hematological, radioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory must—

(i) Meet the management requirements specified in § 405.1316 of this chapter; and

(ii) Provide personnel to direct and conduct the laboratory services.

(A) The laboratory director must be technically qualified to supervise the laboratory personnel and test performance and must meet licensing or other qualification standards established by the State with respect to directors of clinical laboratories. For those States that do not have licensure or qualification requirements pertaining to directors of clinical laboratories, the director must be either—

(1) A pathologist or other doctor of medicine or osteopathy with training and experience in clinical laboratory services; or

(2) A laboratory specialist with a doctoral degree in physical, chemical or biological sciences, and training and experience in clinical laboratory services.

(B) The laboratory director must provide adequate technical supervision of the laboratory services and assure that tests, examinations and procedures are properly performed, recorded and reported.

(C) The laboratory director must ensure that the staff—

(1) Has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;

(2) Is sufficient in number for the scope and complexity of the services provided; and

(3) Receives in-service training appropriate to the type and complexity of the laboratory services offered.

(D) The laboratory technologists must be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory must meet the proficiency testing requirements specified in § 405.1314(a) of this chapter.

(4) The laboratory must meet the quality control requirements specified in § 405.1317 of this chapter.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved by the Medicare program either as a hospital or an independent laboratory.

§ 483.470 Condition of participation: Physical environment.

(a) *Standard: Client living environment.* (1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with others of comparable social and intellectual development.

(b) *Standard: Client bedrooms.* (1) Bedrooms must—

(i) Be rooms that have at least one outside wall;

(ii) Be equipped with or located near toilet and bathing facilities;

(iii) Accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section;

(iv) Measure at least 80 square feet per client in multiple client bedrooms and at least 80 square feet in single client bedrooms; and

(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it must have a window that—

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- (i) Is usable as a second means of escape by the client(s) occupying the room; and
- (ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.
- (3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional—
  - (i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and
  - (ii) Documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.
- (4) The facility must provide each client with—
  - (i) A separate bed of proper size and height for the convenience of the client;
  - (ii) A clean, comfortable, mattress;
  - (iii) Bedding appropriate to the weather and climate; and
  - (iv) Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.
- (c) *Standard: Storage space in bedroom.* The facility must provide—
  - (1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and
  - (2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.
- (d) *Standard: Client bathrooms.* The facility must—
  - (1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;
  - (2) Provide for individual privacy in toilets, bathtubs, and showers; and
  - (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110° Fahrenheit.
- (e) *Standard: Heating and ventilation.* (1) Each client bedroom in the facility must have—
  - (i) At least one window to the outside; and
  - (ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.
- (2) The facility must—
  - (i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and
  - (ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.
- (f) *Standard: Floors.* The facility must have—
  - (1) Floors that have a resilient, non-abrasive, and slip-resistant surface;
  - (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and
  - (3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.
- (g) *Standard: Space and equipment.* The facility must—
  - (1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan.
  - (2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

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(3) Provide adequate clean linen and dirty linen storage areas.

(h) *Standard: Emergency plan and procedures.* (1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

(i) *Standard: Evacuation drills.* (1) The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to—

(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;

(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and

(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility must—

(i) Actually evacuate clients during at least one drill each year on each shift;

(ii) Make special provisions for the evacuation of clients with physical disabilities;

(iii) File a report and evaluation on each evacuation drill;

(iv) Investigate all problems with evacuation drills, including accidents, and take corrective action; and

(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities must meet the requirements of paragraphs (1)(1) and (2) of this section for any live-in and relief staff they utilize.

(j) *Standard: Fire protection—(1) General.* (i) Except as specified in paragraph (1)(2) of this section, the facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association,

1985 edition, which is incorporated by reference.\*

(ii) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(iii) A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds, must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) *Exceptions.* (i) For facilities that meet the LSC definition of a health care occupancy:

(A) The State survey agency may waive, for a period it considers appropriate, specific provisions of the LSC if—

(i) The waiver would not adversely affect the health and safety of the clients; and

(ii) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

(B) The State survey agency may apply the State's fire and safety code instead of the LSC if the Secretary finds that the State has a code imposed by State law that adequately protects a facility's clients.

(C) Compliance on November 26, 1982 with the 1967 edition of the LSC or compliance on April 18, 1986 with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in

\* Incorporation of the 1985 edition of the National Fire Protection Association's Life Safety Code (published February 7, 1985; ANSI/NFPA 101) was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR Part 81 that governs the use of incorporations by reference. The Code is available for inspection at the Office of the Federal Register Information Center, Room 8401, 1100 L Street NW, Washington, DC. Copies may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, Mass. 02269.

If any changes in this Code are also to be incorporated by reference, a notice to that effect will be published in the Federal Register.

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compliance with that edition of the Code.

(j) For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the State survey agency may apply the State's fire and safety code as specified in paragraph (j)(2)(B) of this section.

(k) *Standard: Paint.* The facility must—

(1) Use lead-free paint inside the facility; and  
(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

(l) *Standard: Infection control.*

(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility must implement successful corrective action in affected problem areas.

(3) The facility must maintain a record of incidents and corrective actions related to infections.

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

§ 483.480 Condition of participation: Dietetic services.

(a) *Standard: Food and nutrition services.* (1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, must prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

(b) *Standard: Meal services.* (1) Each client must receive at least three meals daily, at regular times comparable to normal mealtimes in the community with—

(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast; and

(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i) of this section.

(2) Food must be served—

(i) In appropriate quantity;  
(ii) At appropriate temperature;  
(iii) In a form consistent with the developmental level of the client; and  
(iv) With appropriate utensils.

(3) Food served to clients individually and uneaten must be discarded.

(c) *Standard: Menu.* (1) Menus must—

(i) Be prepared in advance;  
(ii) Provide a variety of foods at each meal;  
(iii) Be different for the same days of each week and adjusted for seasonal changes; and  
(iv) Include the average portion sizes for menu items.

(2) Menus for food actually served must be kept on file for 90 days.

(d) *Standard: Dining areas and service.*

The facility must—

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to

meet the developmental needs of each client;

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to assure that each client receives enough food and to assure that each client eats in a manner consistent with his or her developmental level; and

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.

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30-10-205. ICF-MR admission procedure. (a) Admission procedure for ICF's-MR shall be pursuant to 42 CFR 483-440, effective October 3, 1988, which is adopted by reference.

(b) An ICF-MR shall not require a private-paying client to remain in a private-pay status for any period of time after the client becomes eligible for medicaid/medikan.

(c) Each client shall be screened and found eligible for services before the client is admitted in the medicaid/medikan program. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

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well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must—

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) *Standard: Individual program plan.* (1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for ex-

§ 483.440 Condition of participation:  
 Active treatment services.

(a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) *Standard: Admissions, transfers, and discharge.* (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as

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ample, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must—

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

(iii) Identify the client's specific developmental and behavioral management needs;

(iv) Identify the client's need for services without regard to the actual availability of the services needed; and

(v) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives. These objectives must—

(i) Be stated separately, in terms of a single behavioral outcome;

(ii) Be assigned projected completion dates;

(iii) Be expressed in behavioral terms that provide measurable indices of performance;

(iv) Be organized to reflect a developmental progression appropriate to the individual; and

(v) Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan must specify:

(i) The methods to be used;

(ii) The schedule for use of the method;

(iii) The person responsible for the program;

(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

(v) The inappropriate client behavior(s), if applicable; and

(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan must also:

(i) Describe relevant interventions to support the individual toward independence.

(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

(iv) Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

(d) *Standard: Program Implementation.* (i) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

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(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

(e) *Standard: Program documentation.* (1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measureable terms.

(2) The facility must document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

(f) *Standard: Program monitoring and change.* (1) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client—

(i) Has successfully completed an objective or objectives identified in the individual program plan;

(ii) Is regressing or losing skills already gained;

(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

(iv) Is being considered for training towards new objectives.

(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (e) of this section.

(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior,

and persons with no ownership or controlling interest in the facility to—

(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

(ii) Insure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian; and

(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, timeout rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes need to be addressed.

(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

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30-10-206. ICF-MR certification and recertification by physicians. (a) Certification. At the time of admission to an ICF-MR or at the time any ICF-MR client applies for medical assistance under the medicaid/medikan program, a physician or physician extender shall certify that the services must be given on an inpatient basis. Services shall be furnished under a plan established by the physician or physician extender before authorization of payment. Before reimbursement is approved, a screening team designated by the secretary shall review the physician's or physician extender's certification and shall certify that services in an ICF-MR are the most appropriate services available for the individual. The certification of need shall become part of the individual's medical record. The date of certification shall be the date the case is approved for payment and the certification is signed.

(b) Recertification.

(1) Each ICF-MR shall be responsible for obtaining a physician's or physician extender's recertification for each client.

(2) The recertification shall be included in the client's medical record. Recertification statements may be entered on or included with forms, notes, or other records a physician or physician extender normally signs in caring for a client. The statement shall be authenticated by the actual date and signature of the physician or physician extender.

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(c) If the appropriate professional refuses to certify or recertify because, in the professional's opinion, the client does not require ICF-MR care on a continuing basis, the services shall not be covered. The reason for the refusal to certify or recertify shall be documented in the client's records. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

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30-10-207

30-10-207. ICF-MR inspection of care and utilization review. (a) The inspection of care team from the Kansas department of health and environment shall conduct an inspection of care and utilization review of each medicaid/medikan client in all intermediate care facilities for the mentally retarded certified to participate in the medicaid/medikan program.

(b) Each ICF-MR shall cooperate with authorized representatives of the agency and the department of health and human services in the discharge of their duties regarding all aspects of the inspection of care and utilization review.

(c) Any ICF-MR where the utilization review team finds inappropriately placed clients shall be responsible for providing transportation for the clients to a more appropriate placement facility. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991.)

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30-10-208 (1)

30-10-208. ICF-MR personal needs fund. (a) At the time of admission, ICF-MR providers shall furnish that client and the representative with a written statement that:

(1) Lists all services provided by the provider, distinguishing between those services included in the provider's per diem rate and those services not included in the provider's basic rate, that can be charged to the client's personal needs fund;

(2) states that there is no obligation for the client to deposit funds with the provider;

(3) describes the client's rights to select one of the following alternatives for managing the personal needs fund:

(A) The client may receive, retain and manage the client's personal needs fund or have this done by a legal guardian, if any;

(B) the client may apply to the social security administration to have a representative payee designated for purposes of federal or state benefits to which the client may be entitled;

(C) except when paragraph (B) of this subsection applies, the client may designate, in writing, another person to act for the purpose of managing the client's personal needs fund;

(4) states that any charge for these services is included in the provider's per diem rate;

(5) states that the provider is required to accept a client's personal needs fund to hold, safeguard, and provide an accounting, upon the written authorization of the client or representative, or upon appointment of the provider as a client's representative payee; and

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(6) states that, if, in the opinion of the professional interdisciplinary team, the client becomes incapable of managing the personal needs fund and does not have a representative, the provider is required to arrange for the management of the client's personal funds as provided in K.A.R. 30-10-208(j).

(b) (1) The provider shall upon written authorization by the client, accept responsibility for holding, safeguarding and accounting for the client's personal needs fund. The provider may make arrangements with a federally or state insured banking institution to provide these services. However, the responsibility for the quality and accuracy of compliance with the requirements of K.A.R. 30-10-208 shall remain with the provider. The provider may not charge the client for these services, but shall include any charges in the provider's per diem rate.

(2) The provider shall maintain current, written, individual records of all financial transactions involving each client's personal needs fund for which the provider has accepted responsibility. The records shall include at least the following:

- (A) The client's name;
- (B) an identification of client's representative, if any;
- (C) the admission date;
- (D) the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction;
- (E) receipts indicating the purpose for which any withdrawn funds were spent; and
- (F) the client's earned interest, if any.

(3) The provider shall provide each client reasonable access to the client's own financial records.

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(4) The provider shall provide a written statement, at least quarterly, to each client or representative. The statement shall include at least the following:

- (A) The balance at the beginning of the statement period;
- (B) total deposits and withdrawals;
- (C) the interest earned, if any, and;
- (D) the ending balance.

(c) Commingling prohibited. The provider shall keep any funds received from a client for holding, safeguarding and accounting separate from the provider's operating funds, activity funds, client council funds and from the funds of any person other than another client in that facility.

(d) Type of accounts; distribution of interest.

(1) Petty cash. The provider may keep up to \$50.00 of a client's money in a non-interest bearing account or petty cash fund.

(2) Interest-bearing accounts. The provider shall, within 15 days of receipt of the money, deposit in an interest-bearing account any funds in excess of \$50.00 from an individual client. The account may be individual to the client or pooled with other client accounts. If a pooled account is used, each client shall be individually identified on the provider's books. The account shall be in a form that clearly indicates that the provider does not have an ownership interest in the funds. The account shall be insured under federal or state law.

(3) The interest earned on any pooled interest-bearing account shall be distributed in one of the following ways, at the election of the provider:

- (A) Pro-rated to each client on an actual interest-earned basis; or
- (B) pro-rated to each client on the basis of the client's end-of-quarter balance.

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(e) The provider shall provide the clients with reasonable access to their personal needs funds. The provider shall, upon request or upon the client's transfer or discharge, return to the client, the legal guardian or the representative payee the balance of the client's personal needs fund for which the provider has accepted responsibility, and any funds maintained in a petty cash fund. When a client's personal needs fund for which the provider has accepted responsibility is deposited in an account outside the facility, the provider, upon request or upon the client's transfer or discharge, shall within 15 business days, return to the client, the legal guardian, or the representative payee, the balance of those funds.

(f) When a provider is a client's representative payee and directly receives monthly benefits to which the client is entitled, the provider shall fulfill all of its legal duties as representative payee.

(g) Duties on change of provider.

(1) Upon change of providers, the former provider shall furnish the new provider with a written account of each client personal needs fund to be transferred, and obtain a written receipt for those funds from the new provider.

(2) The provider shall give each client's representative a written accounting of any personal needs fund held by the provider before any change of provider occurs.

(3) In the event of a disagreement with the accounting provided by the previous provider or the new provider, the client shall retain all rights and remedies provided under state law.

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(h) Upon the death of a client, the provider shall provide the executor or administrator of a client's estate with a written accounting of the client's personal needs fund within 30 business days of a client's death. If the deceased client's estate has no executor or administrator, the provider shall provide the accounting to:

- (1) The client's next of kin;
- (2) the client's representative; and
- (3) the clerk of the probate court of the county in which the client died.

(i) The provider shall purchase a surety bond in the name of the provider on behalf of the clients or employee indemnity bond, or submit a letter of credit or individual or corporate surety, to guarantee the security of clients' funds when the amount in the aggregate exceeds \$1,000.00. The guarantee shall be sufficient to secure the highest quarterly balance from the previous year.

(j) If a client is incapable of managing the client's personal needs fund, has no representative, and is eligible for SSI, the provider shall notify the local office of the social security administration and request that a representative be appointed for that client. If the client is not eligible for SSI, the provider shall refer the client to the local agency office, or the provider shall serve as a temporary representative payee for the client until the actual appointment of a guardian or conservator or representative payee.

(k) Client property records.

(1) The provider shall maintain a current, written record for each client that includes written receipts for all personal possessions deposited with the provider by the client.

(2) The property record shall be available to the client and the client's representative.

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(l) Providers shall keep the funds in the state of Kansas.

(m) Personal needs fund shall not be turned over to any person other than a duly accredited agent or guardian of the client. With the consent of the client, if the client is able and willing to give consent, the administrator shall turn over a client's personal needs fund to a designated person to purchase a particular item. However, a signed, itemized, and dated receipt shall be required for deposit in the client's personal needs fund envelope or another type of file.

(n) Receipts shall be signed by the client, legal guardian, conservator or responsible party for all transactions. Recognizing that a legal guardian, conservator or responsible party may not be available at the time each transaction is made for or on behalf of a client, the provider shall have a procedure which includes a provision for signed receipts at least quarterly.

(o) The provider shall provide and maintain a system of accounting for expenditures from the client's personal needs fund. This system shall follow generally accepted accounting principles and shall be subject to audit by representatives of the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991.)

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30-10-209. ICF-MR prospective reimbursement. Providers participating in the medicaid/medikan program shall be reimbursed for long term care services through rates that are reasonable and adequate to meet the client-related costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

30-10-210 (1)

30-10-210. ICF-MR reimbursement. Payment for services. (a) Providers with a current signed provider agreement shall be paid a per diem rate for services furnished to eligible medicaid/medikan clients. Payment shall be for the type of medical or health care required by the beneficiary as determined by:

(1) The attending physician's or physician extender's certification upon admission; or

(2) inspection of care and utilization review teams, as provided for in K.A.R. 30-10-207.

However, payment for services shall not exceed the type of care the provider is certified to provide under the medicaid/medikan program. The type of care required by the beneficiary may be verified by the agency prior to and after payment. No payment shall be made for care or services determined to be the result of unnecessary utilization.

(A) Initial eligibility for ICF/MR level services will be determined based on a screening completed by the agency or its designee.

(B) Continued eligibility for ICF/MR level services will be determined by a professional review of the client by the utilization review team of the department of health and environment.

(b) Payment for routine services and supplies, pursuant to K.A.R. 30-10-200, shall be included in the per diem reimbursement and such services and supplies shall not be otherwise billed or reimbursed.

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(1) The following durable medical equipment, medical supplies and other items and services shall be considered routine:

- (A) Alternating pressure pads and pumps;
- (B) armboards;
- (C) bedpans, urinals and basins;
- (D) bed rails, beds, mattresses and mattress covers;
- (E) canes;
- (F) commodes;
- (G) crutches;
- (H) denturē cups;
- (I) dressing items, including applicators, tongue blades, tape, gauze, bandages, band-aides, pads and compresses, ace bandages, vaseline gauze, cotton balls, slings, triangle bandages and pressure pads;
- (J) emesis basins and bath basins;
- (K) enemas and enema equipment;
- (L) facial tissues and toilet paper;
- (M) footboards;
- (N) footcradles;
- (O) gel pads or cushions;
- (P) geri-chairs;..
- (Q) gloves, rubber or plastic;
- (R) heating pads;
- (S) heat lamps and examination lights;
- (T) humidifiers;

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- (U) ice bags and hot water bottles;
- (V) intermittent positive pressure breathing (IPPB) machines;
- (W) I.V. stands and clamps;
- (X) laundry, including personal laundry;
- (Y) lifts;
- (Z) nebulizers;
- (AA) occupational therapy which exceed the quantity of services covered by medicaid/medikan;
- (BB) oxygen masks, stands, tubing, regulators, hoses, catheters, cannulae and humidifiers;
- (CC) parenteral and enteral infusion pumps;
- (DD) patient gowns and bed linens;
- (EE) physical therapy which exceed the quantity of services covered by medicaid/medikan;
- (FF) restraints;
- (GG) sheepskins and foam pads;
- (HH) speech therapy which exceed the quantity of services covered by medicaid/medikan;
- (II) sphygmomanometers, stethoscopes and other examination equipment;
- (JJ) stretchers;
- (KK) suction pumps and tubing;
- (LL) syringes and needles, except insulin syringes and needles for diabetics that are covered by the pharmacy program;
- (MM) thermometers;

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- (NN) traction apparatus and equipment;
- (OO) underpads and adult diapers, disposable and non-disposable;
- (PP) walkers;
- (QQ) water pitchers, glasses and straws;
- (RR) weighing scales;
- (SS) wheelchairs;
- (TT) irrigation solution, i.e., water and normal saline;
- (UU) lotions, creams and powders, including baby lotion, oil and powders;
- (VV) first-aid type ointments;
- (WW) skin antiseptics such as alcohol;
- (XX) antacids;
- (YY) mouthwash;
- (ZZ) over-the-counter analgesics;
- (AAA) two types of laxatives;
- (BBB) two types of stool softeners;
- (CCC) nutritional supplements; and
- (DDD) blood glucose monitors and supplies.

(2) Urinary supplies. Urinary catheters and accessories shall be covered services in the medicaid/medikan program when billed through the durable medical equipment or medical supply provider. This expense shall not be reimbursed in the per diem rate of the cost report.

(3) Nutritional therapy. Total nutritional replacement therapy shall be prior authorized to qualify for reimbursement by the

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durable medical equipment program. If not prior authorized, it is an allowable cost to be covered in the per diem rate.

(c) Payment for ancillary services, as defined in K.A.R. 30-10-200, shall be billed separately when the services or supplies are required.

(d) Payment for a day service program for clients of an ICF-MR shall be included in the per diem reimbursement. Providers shall allow the client or the client's guardian to select a day service program offered by another agency. The other agency must be licensed and unencumbered by documented service deficiencies which would prevent the provider from becoming certified or remaining certified as a medicaid provider. The provider must pay the actual cost of the service provided by the other agency up to 24 percent of the provider's approved per diem rate. Expenses incurred by the provider for this service are allowable expenses and may be reported on the provider's financial and statistical report.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the medicaid/medikan program. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

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30-10-211 (1)

30-10-211. ICF-MR financial data. (a) General. The per diem rate or rates for providers participating in the medicaid/medikan program shall be based on an audit or desk review of the costs reported to provide client care in each facility. The basis for conducting these audits or reviews shall be the ICF-MR financial and statistical report MH&RS-2004. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable and adequate rates. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the ICF-MR and related fields shall be followed, except to the extent that they may conflict with or be superseded by state or federal medicaid requirements. Changes in these practices and systems shall not be required in order to determine reasonable and adequate rates.

(b) Pursuant to K.A.R. 30-10-213, ICF-MR financial and statistical reports, MH&RS-2004, (cost reports) shall be required from providers on an annual basis.

(c) Adequate cost data and cost findings. Each provider shall provide adequate cost data on the cost report. This cost data shall be in accordance with state and federal medicaid requirements and general accounting principles, shall be based on the accrual basis of accounting, and may include a current use value of the provider's fixed assets used in client care. Estimates of costs shall not be allowable except on projected cost reports submitted pursuant to K.A.R. 30-10-213.

(d) Recordkeeping requirements.

(1) Each provider shall furnish any information to the agency that may be necessary:

- (A) To assure proper payment by the program pursuant to paragraph (2);
- (B) to substantiate claims for program payments; and

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(C) to complete determinations of program overpayments.

(2) Each provider shall permit the agency to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include:

(A) Matters of the ICF-MR ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(B) fiscal, medical, and other recordkeeping systems;

(C) federal and state income tax returns and all supporting documents;

(D) documentation of asset acquisition, lease, sale or other action;

(E) franchise or management arrangements;

(F) matters pertaining to costs of operation;

(G) amounts of income received, by source and purpose;

(H) a statement of changes in financial position; and

(I) actual cost of day care programs provided to ICF/MR clients.

Other records and documents shall be made available as necessary. Records and documents shall be made available in Kansas. Any provider who fails to provide any documents requested by the agency may be suspended from the ICF/MR program.

(3) Each provider, when requested, shall furnish the agency with copies of client service charge schedules and changes thereto as they are put into effect. The agency shall evaluate the charge schedules to determine the extent to which they may be used for determining program payment.

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30-10-211 (3)

(4) Suspension of program payments to a provider. If the agency determines that any provider does not maintain or no longer maintains adequate records for the determination of reasonable and adequate per diem rates under the program, payments to that provider may be suspended until deficiencies are corrected. Thirty days before suspending payment to the provider, the agency shall send written notice to the provider of its intent to suspend payments. The notice shall explain the basis for the agency's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies.

(5) All records of each provider that are used in support of costs, charges and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. All financial and statistical records to support costs reports shall be retained for five years from the date of filing the cost report with the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

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**Methods and Standards for Establishing Payment Rates-  
Skilled Nursing and Intermediate Care Facility Rates**

(ICFs/MR)

Usual and Customary Charges

The State shall retain all cost reports for a minimum of three years after receipt.

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30-10-212

30-10-212. ICF-MR extra care. (a) Additional reimbursement for direct services shall be available to ICF's-MR for medicaid/medikan clients in need of extra care. Failure to obtain prior authorization shall negate reimbursement for this service.

(b) Extra care shall be considered a covered service within the scope of the program unless the request for prior authorization is denied. Reimbursement for this service shall be contingent on approval by the agency.

(c) The additional reimbursement for extra care shall be shown as a provider adjustment on the individual line item of benefit on the ICF-MR financial and statistical report. Extra care costs shall not be included as a component when calculating the final rate for the facility. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

#MS-92-20 Approval Date JAN 25 1996 Effective Date 7-1-92 Supersedes TN#MS-91-45

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30-10-213 (1)

30-10-213. ICF-MR cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the ICF-MR financial and statistical report in accordance with the instructions included in this regulation. The report shall cover a consecutive 12-month period of operations. The 12-month period shall coincide with the fiscal year used for federal income tax or other financial reporting purposes. The same 12-month period shall be used by providers related through common ownership, common interests or common control. A non-owner operator of a facility must have a signed provider agreement to be considered a provider for the purpose of this paragraph. A working trial balance, as defined in K.A.R. 30-10-200, and a detailed depreciation schedule shall be submitted with the cost report.

(2) If a provider has more than one facility, the provider shall allocate central office costs to each facility consistently, based on generally accepted accounting principles, including any facilities being paid rates from projected cost data.

(b) Amended cost reports. Amended cost reports revising cost report information previously submitted by a provider shall be required when the error or omission is material in amount and results in a change in the provider's rate of \$.10 or more per client day. Amended cost reports shall also be permitted when the error or omission affects the current or future accounting periods of the provider. No amended cost report shall be allowed after 13 months have passed from the report year end.

(c) Due dates of cost reports. Cost reports shall be received by the agency no later than the close of business on the last day of the third month following the close of the period covered by the report. Cost reports from each provider with more than one facility shall be received on the same date.

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30-10-213 (2)

(d) Extension of time for submitting a cost report to be received by the agency.

(1) A one-month extension of the due date of a cost report may, for good cause, be granted by the agency. The request shall be in writing and shall be received by the agency prior to the due date of the cost report. Requests received after the due date shall not be accepted.

(2) A second extension may be granted in writing by the secretary of the agency when the cause for further delay is beyond the control of the provider.

(3) Each provider who requests an extension of time for filing a cost report to delay the effective date of the new rate, which is lower than the provider's current rate, shall have the current rate reduced to the amount of the new rate. The reduced rate shall be effective on the date that the new rate would have been effective if the cost report had been received on the last day of the filing period without the extension.

(e) Penalty for late filing. Except as provided in subsection (d), each provider filing a cost report after the due date shall be subject to the following penalties.

(1) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be withheld and suspended until the complete ICF-MR financial and statistical report has been received.

(2) Failure to submit cost information within one year after the end of the provider's fiscal year shall be cause for termination from the medicaid/medikan program.

(f) Projected cost data.

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30-10-213 (3)

(1) If a provider is required to submit a projected cost report under K.A.R. 30-10-214, the provider's rate or rates shall be based on a proposed budget with costs projected on a line item basis for the provider's most immediate future 12-month period.

(2) The projection period shall end on the last day of a calendar month. Providers shall use the last day of the month nearest the end of the 12-month period specified in subparagraph (1) or the end of their fiscal year when that period ends not more than one month before or after the end of the 12-month report period. The projection period shall not be less than 11 months or more than 13 months. Historical cost data reported shall be for the full period reported if that period is less than 12 months or the latest consecutive 12-month period if the report period is extended beyond 12 months to meet this requirement.

(3) The projected cost report shall be approved for reasonableness and appropriateness by the agency before the rate or rates are established for the projection period, and upon receipt of the provider's historical cost report for the time period covered by the projected cost report. The projected cost report items which are determined to be unreasonable or which contain deviations from the historical cost report shall, upon audit, be handled in accordance with subsection (f) of K.A.R. 30-10-214.

(4) The projection period of each provider filing a projected cost report in accordance with paragraph (2) of subsection (e) of K.A.R. 30-10-214 shall be extended to the last day of the 12th month following the date the new construction is certified for use by the appropriate agency. The projected and historical cost reports for this projection period shall be handled in accordance

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30-10-213 ( )

with paragraph (1) of this subsection. If the projection period prior the certification of the new construction exceeds three months, the provider shall be required to file a historical cost report for this period for the purpose of retroactive settlement in accordance with paragraph (1) of this subsection.

(5) An interim settlement, based on a desk review of the historical cost report for the projection period, may generally be determined within 90 days after the provider is notified of the new rate determined from such cost report. The final settlement shall be based on an audit of the historical cost report.

(g) Balance sheet requirement. A balance sheet prepared in accordance with cost report instructions shall be filed as part of the cost report forms for each provider. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

(h) Any facility on projected status on October 1, 1991 will continue on projected status to the end of the projection period. The rate will then be developed according to this subpart.

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**Methods and Standards for Establishing Payment Rates-  
Skilled Nursing and Intermediate Care Facility Rates**

(ICFs/MR)

**Audits**

1. The SRS Office of Audit Services uses a standardized ICF/MR desk review program and a standardized field audit program.
2. The State shall perform a desk review of all cost reports within six months after receipt.
3. The State shall provide for periodic audits of the financial and statistical records of participating providers.
4. Installment recoupments shall be allowed if the Department determines that a lump sum recoupment could result in the provider being unable to provide a standard level of care. Any payment schedules in excess of twelve months shall be approved by the Secretary.

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INSTRUCTIONS FOR COMPLETING  
THE ICF-MR  
FINANCIAL AND STATISTICAL REPORT  
(FORM MH&RS-2004)

PURPOSE

The purpose of this report is to obtain the client-related costs incurred by intermediate care facilities for the mentally retarded (ICF-MR) in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The regulations governing the completion of this report and adult care home reimbursement can be found in the Kansas Administrative Regulations, Chapter 30, Part 200.

SUBMITTAL INSTRUCTIONS

1. One blank Form MH&RS-2004, ICF-MR Financial and Statistical Report, is sent by Mental Health and Retardation Services to each ICF-MR in the Medicaid/Medikan Program before the end of the home's reporting period.
2. Send two copies of the completed form MH&RS-2004 and one copy of the form AU-3902 (Census Summary) for each month of the reporting period to the following address:

ICF-MR Reimbursement  
Mental Health and Retardation Services  
Department of Social & Rehabilitation Services  
Docking State Office Building, 5th Floor  
915 S.W. Harrison  
Topeka, Kansas 66612

Attention: Administrator, ICF-MR Reimbursement

3. All inquires on completion of these forms should be directed to the Administrator, ICF-MR Reimbursement, Mental Health and Retardation Services, at (913) 296-3561.

GENERAL

1. COMPLETE THE FORMS ACCURATELY AND LEGIBLY. ANY REPORT THAT IS INCOMPLETE OR IS NOT LEGIBLE WILL BE PROMPTLY RETURNED TO THE PROVIDER. THIS MAY POSTPONE THE RATE EFFECTIVE DATE AND RESULT IN ADDITIONAL PENALTIES FOR LATE FILINGS. KAR 30-10-213
2. ALL TOTALS MUST BE ROUNDED TO THE NEAREST DOLLAR.
3. DO NOT ADD LINES TO THE FORMS. Use "OTHER" lines for client-related expenses not designated on the Expense Statement, Schedule A. Attach a schedule if necessary.
4. DO NOT CROSS OUT OR RETITLE LINES ON THE FORMS. DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE. IF MORE THAN ONE AMOUNT OR JOURNAL ENTRY IS COMBINED, SUBMIT AN ATTACHMENT WITH EXPLANATION.

6. USE THE ACCRUAL METHOD OF ACCOUNTING IN REPORTING FINANCIAL DATA. Revenues are reported in the period when earned, and not when received, and expenses are reported when incurred, not when paid.
7. ESTIMATES OF REVENUES AND EXPENSES ARE NOT ACCEPTABLE.
8. ALL COST REPORTS, HISTORICAL OR PROJECTED, MUST BE FOR A PERIOD OF 12 CONSECUTIVE MONTHS EXCEPT AS PROVIDED IN KAR 30-10-213. Providers who have filed a projected cost report must file a historical report for the projection period and a historical report for the first fiscal year following the end of the projection period.
9. ALL COST REPORTS MUST BE RECEIVED BY THE AGENCY NO LATER THAN THE CLOSE OF BUSINESS ON THE LAST DAY OF THE THIRD MONTH FOLLOWING THE END OF THE REPORTING PERIOD (FISCAL YEAR END OR PROJECTION). KAR 30-10-213. The provider may request a one month extension of the due date by submitting the request in writing to the address in the Submittal Instructions within the time period allowed for filing the original cost report. The extension will be granted if the agency determines that the provider has shown good cause. NOTE: IF A COST REPORT IS RECEIVED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES SPECIFIED IN KAR 30-10-213.
10. EACH ICF-MR MUST MAINTAIN ADEQUATE ACCOUNTING AND/OR STATISTICAL RECORDS. Inadequate recordkeeping is cause for suspension of payments or reduction to the lowest rate(s) for the level(s) of care provided. KAR 30-10-211.
11. REIMBURSEMENT RATES (PER DIEM) FOR ICF'S-MR: The per diem rate of reimbursement for those facilities participating in the medicaid/medikan program is based on the reported costs and client days as adjusted by a desk review of the cost report. Each cost report is also subject to a field audit to arrive at a final settlement for the period the per diem rate was based upon.
12. KANSAS ADMINISTRATIVE REGULATIONS: Copies of the regulations governing ICF-MR medicaid/medikan reimbursement may be obtained at a cost by sending a request to the Department of Social and Rehabilitation Services to the address given in the submittal instructions. NOTE: SINCE THE REGULATIONS MAY BE CHANGED, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM MH&RS-2004 FOR SUBMISSION.

### COST REPORT INSTRUCTIONS

#### COVER PAGE

#### A) Provider Identification

LINES 11-19 Complete these lines as indicated on the report form.

LINE 21 THROUGH 25: Check Only One Box.

LINE 21 Check if the cost data is for the provider's normal fiscal year and does not include any portion of a projection period.

- LINE 22 Applies to projected cost reports for new providers that are not occupying a newly constructed facility.
- LINE 23 Applies only to projected cost reports related to newly constructed facilities. If a provider occupies a newly constructed facility they should check this box. Providers that have increased total beds available through new construction to an existing facility by 25% or more may file a projected cost report and should check this box.
- LINE 24 Applies only to providers filing historical cost reports for the same 12 month period as their projection year.
- LINE 25 Applies to providers in the process of converting from the projection period to their normal fiscal year and the report period includes a portion of the projection period.

LINES 26 THROUGH 32 Check only one box. Check the type of business organization which most accurately describes your facility or explain on line 32.

B) Facility Beds:

LINES 43 THROUGH 45 Enter the number of licensed beds available for each category listed. If a change in the number of beds has occurred during the reporting period, show the increase (or decrease) and the date of the change. Total the categories on line 45. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

LINE 46 TOTAL BED DAYS AVAILABLE: If the number of beds available throughout the year has not changed, the total number of bed days is computed by multiplying the number of beds times 365 (366 in leap years). If the number of beds change during the period, compute as shown in the example below.

Assume a home of 20 beds was increased on July 1 to 25 beds, the number of bed days for the period would be determined as follows:

January 1 to June 30 - 181 days x 20 beds =	3,620 bed days
July 1 to December 31 - 184 days x 25 beds =	4,600 bed days
	<u>8,220</u> bed days for period

LINE 48 TOTAL CLIENT DAYS: The total number of client days shall be determined in accordance with K.A.R. 30-10-225. A client day means that period of service rendered to a client between the census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Medicaid/Medikan or non-Medicaid/Medikan client who was not in the home (K.A.R. 30-10-1a). If both the admission and discharge occur on the same day, it shall count as a client day. If the provider does not make refunds on behalf of a client for unused days in the case of death or discharge, and if the bed is available and actually used by another

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client, these unused days shall not be counted as a client day. Any bed days paid for the client before an admission date shall not be counted as a client day. The total client day count for the cost report period shall be accurate. An estimate of the days of care provided shall not be acceptable. The total client days must agree with the 12 month total as submitted on the form AU 3902.

Day care and day treatment shall be counted as one client day for 18 hours of service. The clients of day care/treatment shall be listed on the monthly census summary (AU 3902) with the number of hours reflected on the appropriate day column.

OCCUPANCY PERCENTAGE - Agency staff will determine this percentage.

LINE 48a TOTAL MEDICAID/MEDIKAN DAYS - Enter the total number of Medicaid/Medikan days reported on the AU 3902's. Partial as well as full paid days must be included (please refer to KAR 30-10-225).

LINE 50 AGENCY USE ONLY.

LINE 51 If the provider is a publicly held entity, provide annual reports and Form 10-K.

Declaration by Owner and Preparer: The cost report is not considered complete unless signed by a representative of the facility (i.e. owner, officer, administrator, etc.) and the preparer. If the facility representative and the preparer are the same individual, please sign both spaces. PLEASE READ DECLARATION STATEMENT.

SCHEDULE A - EXPENSE STATEMENT

ATTACH A COPY OF THE WORKING TRIAL BALANCE USED TO PREPARE THE COST REPORT.

Column 1 - Per Books or Federal Tax Return: Report the expenses reflected in the accounting records under the appropriate cost center (i.e. Administration, Ownership, Plant Operating, Room and Board, Habilitation and Non-Reimbursable). The total of all the expense lines (Column 1 - Line 210) shall reconcile to the accounting records and/or income tax return.

Column 2 - Provider Adjustments: Enter the necessary adjustments to the expenses reported in Column 1 that are not client-related according to the regulations and/or offset expense recoveries reported in the Revenue Statement (Schedule G). Attach a schedule if necessary.

Column 3 - Client Related Expense: Enter the difference between Column 1 and Column 2. Please complete Column 3 even if no adjustments were made in Column 2, except for lines 191 through 209.

Columns 4 & 5 - SRS Adjustments/Adjusted Client Related Expenses: Leave blank - FOR AGENCY USE ONLY.

Expense Lines (General): All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. For example, telephone expense is included in the Administration cost center. Therefore, the expense for telephone lines to the nurses' station shall not be reported in the Habilitation cost center. See specific line instructions for more detail. DO NOT CROSS OUT OR USE A LINE DESIGNATED FOR A PARTICULAR TYPE OF EXPENSE FOR SOME OTHER TYPE OF EXPENSE.

THE SPECIFIC INSTRUCTIONS, WHICH FOLLOW, DO NOT COVER EACH LINE ITEM OF THE EXPENSE STATEMENT, BUT ARE DESIGNED TO COVER ITEMS WHICH MAY REQUIRE ADDITIONAL EXPLANATION OR EXAMPLES.

All Salaries - Lines - 101, 102, 103, 126, 142, 149, 154, 161, 162, 163, 171 and 173. Salaries are compensation paid for personal services that were reported to the Internal Revenue Service (IRS). These lines, plus the owner/related party compensation lines, shall reconcile to your IRS 941 Report forms as adjusted by benefits or other bonuses.

Each facility must have a licensed administrator or QMRP. Non-owner/related party administrator compensation shall be reported on line 101. Owner/related party administrator compensation shall be reported on 107. Salaries of the administrator and co-administrator paid as central office costs shall be reported on lines 101 and 102.

Salaries and benefits of the administrator and co-administrator paid through the central office shall be reported on lines 101 and 102.

Employee Benefits - Lines 104, 127, 141, and 164 - Allocate employee benefits to the benefit lines in each cost center based on the percentage of gross salaries or the actual amount of expense incurred in each center. Employee benefits, if offered to substantially all employees may include but are not limited to:

- 1) Employer's share of payroll taxes
- 2) State and federal unemployment contributions
- 3) Workers' compensation insurance
- 4) Group health and life insurance
- 5) Employee "non-cash" gifts
- 6) Moving/relocation expenses
- 7) Employee retirement plans
- 8) Employee parties - except alcoholic beverages
- 9) Profit sharing
- 10) Physical examinations
- 11) Malpractice insurance that specifically protects employees. This shall be specifically identified on the insurance bill from the agent.
- 12) Employee Uniforms

Employee benefits shall not include:

- 1) Employee cash bonuses and/or incentive awards - these payments shall be considered additional compensation and be reported on salary lines.

- 2) Benefits given to owner/related parties but not to substantially all employees - these benefits shall be treated as additional compensation and be reported on owner/related party compensation lines.

Employee benefits with restrictions include:

- 1) Employee benefits offered to select non-owner/related party employees shall be reported as a benefit in the cost center in which the salary is reported.

Consultants - lines 106, 144, 166, and 175 through 180. Report all fees paid to professionally qualified non-salaried consultants. List the titles of other habilitation consultants on line 180.

NOTE: Line 106 - Management Consulting Fees. Include only cost of arms-length management consultant fees. Owner/related party management fees shall be reported on line 107. Also see instructions to line 108.

Owners and Related Party Compensation - Lines 107, 128, 143, 165, 172 and 193. Record the amount earned and reported to IRS for client related services of owner/related parties. In order to be allowed, the compensation must be paid within 75 days after close of the fiscal period. The amount reported must be in agreement with entries made in Schedule B. Compensation may be included in allowable cost only to the extent that it represents reasonable remuneration for managerial and administrative functions, professionally qualified habilitation services and other services related to the operation of the ICF-MR, and was rendered in connection with client care. All compensation paid to an owner/related party shall appear on the appropriate lines above regardless of the label placed on the services rendered. See K.A.R. 30-10-221. NOTE: Line 143 is for reporting owner/related party compensation for Dietary, Laundry and Housekeeping services

"Other" - Lines 117, 118, 138, 148, 153, 158, 170, 183, 188, and 208. "Other" or blank lines have been provided in each cost center. Types of expense entered on these lines shall be identified and be applicable to the cost center unless further restricted. Attach a schedule to the cost report if necessary. Failure to do so can cause unnecessary delay in the processing of your cost report and can result in a delayed rate effective date of your new rate.

Line 105 - Office Supplies and Printing. Report all office supplies, postage, duplicating and printing expenses on this line. The printing and duplicating of forms are considered to be an administrative expense and shall not be reported in any other cost center. The exception to this rule is habilitation records forms which may be reported on line 168, nursing supplies.

Line 108 - Allocation of Central Office Costs. All providers with more than one facility and pooled administrative costs shall report allocated costs on line 108. All facilities, including the central office, must use the same reporting period. (KAR 30-10-213 & 30-10-224). ATTACH A DETAILED SCHEDULE LISTING THE CENTRAL OFFICE COSTS AND METHOD OF ALLOCATION TO ALL FACILITIES AND PROGRAMS.

Allowable central office costs are subject to the following conditions:

- Purchases from related-party vendors - Costs of client-related goods and services supplied to the central office by related parties will be allowed at the lower of the cost to the vendor or the charge to the central office;
- Management consulting fees - If the management services company is owned or controlled by the company or person(s) that owns or controls the facilities, the management fees must be reported as central office costs subject to the limits of related-party transactions;
- Salaries of owner/related parties - Any of these costs that are included in central office costs must be reported on line 107;
- Central office bulk purchases of ICF-MR supplies - These expenses may be allocated to the supplies lines in the appropriate cost centers; and
- Direct care consultants - These costs may be reported on the applicable consultant lines in the appropriate cost centers.

Line 109 - Telephone and Other Communication. Report routine telephone and communications expense on this line regardless of the department or cost center benefit.

Line 110 - Travel - Report administrative and staff travel expenses that are related to client care. VEHICLE COSTS MUST BE DOCUMENTED BY DETAILED EXPENSE AND MILEAGE RECORDS KEPT AT THE TIME OF THE TRAVEL ACTIVITY. Estimates shall not be acceptable.

EXCEPTIONS:

- 1) Long term or recurring vehicle lease expense for business purposes shall be reported on line 123.
- 2) Expenses associated with the personal use of a vehicle are not allowable unless reported within otherwise allowable limits of compensation.
- 3) Costs related to "in town" entertainment are non-allowable.
- 4) Travel expenses related to PROVIDER board meetings are non-allowable.
- 5) Client transportation expense shall be reported on line 182.
- 6) Vehicle maintenance and repair shall be reported in the Plant Operating Cost Center.

Line 111 - Advertising - Report allowable advertising expense on this line. This line shall be used for employment advertisements and ads in telephone directories. Fund raising, public relations, advertising for client utilization and sponsorships are not allowable and shall be reported on line 195.

Line 112 - Licenses and Dues - Report all licenses and dues expense on this line. Personal automobile club memberships are not allowable unless reported as compensation.

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Line 113 - Legal, Accounting and Data Processing (DP) - Report legal and accounting expense on this line, except fees paid to owner/related party firms or individuals which must be reported on the owners compensation line 107. Data processing expense related to financial management (i.e. accounting, payroll, budgeting, etc.) shall be reported on this line.

Line 114 - Insurance - Report property and liability insurance expense on this line. Workers' compensation and employee health and life insurance expense shall be reported on employee benefit lines. The premium for "Key Employee" life insurance (when the corporation is made the beneficiary of the policy) is not an allowable expense, and shall be reported on line 196.

Line 115 - Interest - Report the interest expense related to operating loans and equipment purchases. Submit copies of each new note for the year originated.

Line 117 or 118 - Other - Include amortization of administrative organizational and/or start-up costs. Also include client related expenses for education of administrative staff.

Line 122 - Interest on Real Estate Mortgage - Report all interest expense incurred for the acquisition or construction of real estate. Describe fully on Schedule D. Include amortization expense for loan costs. The interest for equipment and furnishings purchased along with the building shall be reported on this line.

Line 123 - Rent or Lease Expense - Report all recurring rent and lease expense regardless of the item and use.

Line 124 - Amortization of Leasehold Improvement. Report only amortization of leasehold improvements on this line. Leasehold improvements are defined as betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

Line 125 - Depreciation Expense - This amount must be computed by the straight-line method. Such amounts must be reconciled to a detailed depreciation schedule. The determination of capitalized property must be in conformity with Generally Accepted Accounting Principles. If an item or related items purchased in bulk (beds, chairs, tables, etc.) exceed a cost of \$1,000, they shall be capitalized. ATTACH A DETAILED DEPRECIATION SCHEDULE TO THE COST REPORT.

Line 121 - Real Estate and Personal Property Taxes - Report all real and personal property taxes on this line.

Line 126 - Salaries - Report salaries of maintenance personnel who perform carpentry, mechanical, electrical, plumbing, heating, cooling and painting duties.

Line 129 - Utilities Except Telephone - Report expenses for gas, water, electricity, heating oil, etc. Cablevision may be considered a utility or client activity expense.

Line 130 - Maintenance & Repair - Report all maintenance and repair expenses applicable to the building, grounds, equipment and vehicles.

Line 131 - Supplies - Report supplies expense incidental to the operation and maintenance of the building, grounds, and equipment.

Line 137 - Small Equipment - Equipment purchases of \$500 to \$1,000 that were not capitalized must be expensed on this line. Equipment purchases of \$1 to \$499 may be reported in the cost center of benefit as a supply expense.

Line 138 - Other - Report miscellaneous expenses incidental to the operation and/or maintenance of the facility and grounds. These include but are not limited to trash hauling, snow removal and lawn care. This line shall be used for training and educational expense for employees with salaries reported in the Plant Operating Cost Center.

Line 141 - Employee Benefits - Report total employee benefits associated with Dietary, Laundry and Housekeeping salaries.

Line 145 - Food - Report all food costs. Nutritional supplements are to be included on this line. The ICF-MR shall be required to keep records on the number of meals served in the ICF-MR including employees, guests, and outside programs. If the food expense for the employees, guests, and outside programs is included in the MS-2004a expenses, the expense should be offset against the dietary cost center as follows:

- A. Line 141 - Dietary Portion Employee Benefits
- Line 142 - Dietary Salaries
- Line 143 - Dietary Owner/Related Party Compensation
- Line 144 - Dietary Consultant
- Line 145 - Food
- Line 146 - Dietary Supplies
- Line 148 - Other

Total Dietary Cost divide number of meals served = cost per meal

- B. Cost per meal X number of meals served to employees, guests, and outside programs = amount of offset.

Line 146 - Supplies (Dietary) - Report supplies expense directly related to the preparation and service of food to the clients unless further restricted by another expense line (i.e. printed menus are reported on line 105 - Office Supplies and Printing). Examples include but are not limited to paper goods, kitchen utensils, etc.

Line 148 - Other (Dietary) - Report and specify miscellaneous expenses directly related to the preparation and service of food to the clients unless restricted by another expense line (i.e. all repairs and maintenance are plant operating costs). Report dietary related education and training expense for the dietary employees.

Line 150 - Linen and Bedding Materials - Report linen and bedding materials expenses on this line

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Line 151 - Laundry and Linen Supplies - Report all supplies expense directly related to laundry and linen services for the clients, unless restricted by another line.

Line 153 - Other (Laundry) - Report all other expenses directly related to laundry and linen services for the clients unless restricted by another line. Report laundry employee in service and training costs for employees reported in laundry salaries. in line 149.

Line 154 - Salaries (Housekeeping) - Report the salaries of housekeeping and janitorial staff involved in floor care and in cleaning of the building.

Line 155 - Supplies (Housekeeping) - Report all supplies expense related to keeping the building clean and sanitary. Floor care supplies shall be expensed on this line.

Line 158 - Other (Housekeeping) - Report (and specify) miscellaneous expenses directly related to the provision of housekeeping for the facility, unless restricted by another expense line. Pest extermination may be expensed on this line or in the Plant Operating cost center. Report housekeeping related education and training for employees reported on housekeeping salaries.

Line 163 - Other Habilitation Personnel - Record the compensation of all other salaried habilitation personnel who are involved in direct client care.

Line 167 - Purchased Services - This line shall be used to report all habilitation related contract labor or other services.

Line 168 - Nursing Supplies - Report expenses of all ROUTINE supplies directly related to the provision of nursing and/or habilitation services for clients, unless further restricted by another expense line. Medical records forms may be expensed on this line.

Line 171 - Therapy/Other Salaries - Report the salaries of therapists and other employees who are directly involved in providing habilitation (i.e. medical records technician).

Line 173 - Client Activities/Social Worker Salaries - Report the salaries of the client activities personnel and/or social workers on this line.

Line 174 - Client Activity Supplies - Report the supplies expense involved in providing client activities. This does not include the cost of newsletters.

Lines 175-180 - Consultants - Not applicable.

Line 181 - Employee Training - Report the costs of fees, tuitions, books, etc. for education or training seminars provided to employees who are directly involved in client care and training. Travel, lodging and meals associated with the education/seminars may be reported on this line.

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ICF-MR Financial and Statistical Report

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Line 182 - Client Transportation - Report client transportation expense incurred for non-emergency medical, shopping, client activities, etc. in which the clients are the primary passengers. Trip logs must be kept to document the expense. Do not include vehicle lease, interest, depreciation, insurance or other expenses restricted to another expense line.

Acceptable methods of allocating cost to line 182, Client Transportation are as follows:

(1) Allocated at a set rate per mile. The rate would be determined by dividing total vehicle expense, not restricted to another expense line, by the total miles. The IRS allowed rate per mile is not acceptable because it includes factors for depreciation, insurance and repairs.

(2) Allocated directly per the following formula:

$$\frac{\text{Resident Travel Miles}}{\text{Total Miles}} \times \text{Total Vehicle Expenses Not Restricted to Another Expense Line} = \text{Client Travel Expense}$$

(3) If private vehicles are used to transport clients, the entire amount of the reimbursement paid to the employee for use of the vehicle is allowable as Client Transportation. The rate of reimbursement must, however, be reasonable.

General: Non-Reimbursable & Non-Client Related Items (Lines 191 - 209) Provider adjustments must be made in column 2 that offset column 1 expenses in total. Column 3 will show zero expenses. Note: The Totals on lines 190 and 210 in column 3 will be the same amount.

Line 195 - Fund Raising/Public Relations/Advertising for Client Utilization - Include non-allowable advertising expenses. See line 111 - Advertising.

Line 197 - Oxygen Purchases & Supplies - Billing for reimbursement of oxygen, cylinder rental and allowable supplies is to be done by the oxygen supplier to the fiscal agent. Homes with a central supply are to bill the fiscal agent directly.

Line 198 - Drugs - Pharmaceuticals - Report expenses for prescription drugs and other items not covered as a routine item in the Kansas Adult Care Home Medicaid/Medikan Provider Manual on this line.

Line 202 - Client Purchases - Report the expense for items purchased for clients but not listed as routine services or supplies in the Kansas Adult Care Home Medicaid/Medikan Provider Manual - on this line.

Line 204 - Work Activity/Production Costs - Report items specified in KAR 30-10-218.

EXPENSE RECONCILIATION

General: This schedule shall be used to reconcile the expenses reported on the Financial and Statistical reports for ICF-MR (Form MH&RS-2004) to the provider's financial books and federal tax return.

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Column 1 - Books - Reflect the expenses as they appear in the general ledger or other financial records.

Column 2 - Federal Tax Return - Reflect the expenses as they appear on the federal tax return.

Column 3 - Cost Report - Reflect the expenses as they were reported on the cost report Schedule A - Expense Statement.

Line 231 - Total Expenses Per Books - Record the total expenses per the general ledger or other financial records in Column 1.

Line 232 - Total Expenses Per Federal Tax Return - Record total expenses from tax return in Column 2.

Line 233 - Total Expenses Per Cost Report - Enter total expenses from Schedule A - Expense Statement (Column 1 line 210) in Column 3.

Lines 234 & 235 - Expenses on Books or Federal Tax Return Not on Cost Report - Itemize each expense reflected in the books or federal tax return and not included in the cost report. These expenses should be recorded in the appropriate column under books and/or federal tax return as an offset to the total expense in that column. Use an additional schedule if necessary to list expenses.

Lines 237 & 238 - Expenses on Cost Report Not on Books or Federal Tax Return - Itemize the expense reflected in the cost report but not in the total from the books or tax return. These items should be offset to the total expense in Column 3 - Cost Report. Use an additional schedule if necessary.

Line 240 - Totals - The differences between the totals per lines 231 (books), 232 (federal tax return) and 233 (cost report) less the negative adjustments in lines 234 - 238 in each of the three columns shall be entered on line 240. The adjusted totals per the books, federal tax return and cost report shall agree after the applicable offsets to the total expenses reported.

SCHEDULE B - STATEMENT OF OWNERS AND RELATED PARTIES

**General:** List all owners of the provider entity with 5% or more ownership interest and all related parties (KAR 30-10-221). Fill out Schedule B completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to client care and the prevailing wage rates for such activities.

**ENTER:** Name, Social Security Number and Address

Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties as defined in KAR 30-10-200 and KAR 30-10-221.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job titles should correspond with those included in the Owner/Related Party Salary Chart Prepared by SRS (please refer to KAR 30-10-221).

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense line (107, 128, 143, 165, 172 and 193) in Schedule A.

**Totals** - The total compensation in Column 3 and Column 5 should agree. These two totals should also agree with the total of lines 107, 128, 143, 165, 172 and 193 Schedule A.

SCHEDULE C - SALARIES AND WAGES

**General:** All salaries paid to ICF-MR employees, except owners and related parties compensation reported on Schedule B, shall be reported on this schedule. Total salaries reported on Schedule C should equal the sum of the non-owner salary lines in Schedule A, Column 1 - Expense Statement. ROUND TO THE NEAREST DOLLAR.

**Line Number:** ALL SALARIES, EXCEPT OWNER/RELATED PARTY COMPENSATION, SHALL BE REPORTED ON THESE LINES ONLY.

**Position/Title:** These are the descriptions of the salary expense lines in Schedule A. No further break-down by job title is needed for salaries reported on lines 103 - Other Administrative Salaries, 126 - Property Salaries, 142 - Dietary Salaries, 149 - Laundry Salaries and 154 - Housekeeping Salaries.

Job titles are required for salaries reported in the Habilitation Cost Center. If a job title is not provided, list it on an "Other" line by the corresponding line number. Habilitation salaries shall be appropriately classified so that the information can be used for analytical purposes.

Column 16 - Total Hours Paid: Enter the total hours paid during the reporting year for each group of salaried and hourly employees. The paid hours include holidays, sick days, vacation, etc.

Column 17 - Salaries & Wages: Enter the total amount paid to each group of employees during the reporting year.

SCHEDULE D - STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

NOTE: Please submit copies of loan agreements and amortization schedules with this cost report for all loans of \$5,000 or more. Failure to document interest expenses is cause for disallowance. KAR 30-10-211. Schedules need to be submitted for related party loans showing the interest paid, check numbers and dates.

Column (1) - Enter the original date and duration of the loan.

Column (2) - Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.

Column (3) - Enter the amount of the loan.

Column (4) - Enter the unpaid principal balance at the end of the cost report period. The total of Column 4, Line 311, must agree with the balance sheet, Schedule E.

Column (5) - Enter the total amount of interest and principal payments made during the cost report year.

Column (6) - Enter the total amount of interest incurred during the cost report year. The total of Column 6, Line 311 must agree with the total interest report on Schedule A lines 115 and 122.

Lines 301 - 306 - Enter each lender's name, address and the items financed.

Line 311 - Enter the totals of Column 4 - Unpaid Balance and Column 6 - Interest Expense, for lines 301-306.

SCHEDULE E - BALANCE SHEET

General: The balance sheet should be prepared from the books of the specific facility for which the cost report is filed. In other words, chain units should report only those balance sheet accounts that relate to the particular facility for which the cost report applies. Subject to the above, the balance sheet must be prepared in conformity with generally accepted accounting principles. Report all ownership claims that are customarily used by your particular type of entity. A partial listing of these accounts by type of entity follows:

Individual Proprietor ----- Owner's Capital  
 Partnership ----- Partner's Capital Accounts  
 Not-for-Profit Entities ----- Fund Balance  
 Corporation ----- Common Stock, Additional Paid in  
 Capital, Retained Earnings  
 Chain Unit--All Chain Units ----- Central or Home Office Account  
 Regardless of Type of Ownership

NOTE: Beginning of period account balances shall be reported for providers allowed to submit projected cost reports.

Lines 355, 356, 357 & 373 - If the amount reported exceeds \$10,000, attach a schedule showing the details.

SCHEDULE F - RECONCILIATION OF BEGINNING AND ENDING RESIDUAL BALANCES

General: This schedule explains the change in owner's equity or the fund balance from the beginning to the end of the cost reporting period.

BEGINNING BALANCE

Line 401 - Enter the beginning owner's equity or fund balance. This is the total of Column 2 lines 377-379 in the balance sheet (Schedule E).

INCREASES TO OWNER'S EQUITY OR FUND BALANCE

Line 402 - Enter total revenue from Schedule G, column 1, Line 449.

Line 403 - Enter the total of cash or other assets transferred or contributed by the owners.

Line 404 - Enter total of cash or other assets transferred or contributed by the central office.

Line 405 - Enter the proceeds from the sale of common stock.

Line 406 & 407 - Enter and specify all other transactions which increase the residual owner equity or fund balance accounts.

Line 408 - Enter the total of lines 402-407.

DECREASES TO OWNER'S EQUITY OR FUND BALANCE

Line 411 - Enter the total expenses per Schedule A, Column 1, Line 210.

Line 412 - Enter total of cash or other assets withdrawn by the owners but not reported in Schedule A - Expense Statement.

Line 413 - Enter total cash or other assets withdrawn by the central office.

Line 414 - Enter the total of duly declared dividends paid to stockholders.

Line 415 - Enter the depreciation expense in excess of the straight line method unless reflected as a negative adjustment in Schedule A, Column 2.

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Line 416 & 417 - Enter and specify all other transactions which decrease the residual owner equity or fund balance accounts.

Line 418 - Enter the totals of line 411-417.

ENDING BALANCE

Line 419 - Enter the net of adding lines 401 and 408 and subtracting line 418. The balance at the end of the period (line 419) should equal the total of Column 4, lines 377-379 in the balance sheet (Schedule E).

SCHEDULE G - REVENUE STATEMENT

Column 1 - Enter the revenues from the general ledger accounts on the appropriate lines. Revenues from services not designated on this schedule must be identified and reported on lines 447-448. The amount of the total revenue entered on line 449, Column 1 must also be entered on line 402, Reconciliation of Beginning and Ending Residual Balances, Schedule F.

Column 2 - Enter the amount of the offset to the appropriate expense accounts. NOTE THE FOLLOWING: The amount of the offset should be the lesser of the revenues or cost of reimbursable expenses. Non-reimbursable items (i.e. Beauty & Barber, Vending) are offset at cost.

Column 3 - Enter the line number of the expense reported on the Expense Statement, Schedule A, against which the offset has been made. The amount of the offset must be entered in Column 2, Provider Adjustments, on the Expense Statement, Schedule A.

Line 437 - Nursing Supplies Sold to Private Pay Client.

- (1) There is no offset required for items covered under KAR 30-10-210 that are sold to private pay clients; and
- (2) None of the items covered under KAR 30-10-210 can be sold to Medicaid clients.

Line 440 - Client Purchases - Enter the total of all reimbursements for personal purchases not designated as routine items in the Kansas Adult Care Home Provider Manual on this line.

Line 446 - Day Care/Treatment - Enter total revenue from all sources for day care, day treatment and respite care programs.

SCHEDULE H - STATEMENT OF RELATED ICF-MR FACILITY INFORMATION

General: All Kansas facilities operated by common ownership or related parties shall be listed. Common ownership and related parties are defined in KAR 30-10-200. Additional schedules shall be attached as necessary.

SCHEDULE I - FIXED ASSET, DEPRECIATION AND AMORTIZATION QUESTIONNAIRE

General: Each question shall be answered completely and accurately.

Lines 482-489 - Complex Capital Structures:

Attach a complete explanation of the ownership/management structure of the ICF-MR including owners with 5% or more interest in the property and/or business, related parties as defined in KAR 30-10-200, and all relevant contracts, leases, and assignments. This information must be accurate and comprehensive enough to present a true and clear account of the ownership and control of the ICF-MR.

Line 491 - If the facility is leased, a copy of the original lease agreement and subsequent amendments and/or agreements shall be submitted and on file with the agency. A provider making payments under Industrial Revenue Bonds with a nominal purchase upon maturity shall report the cost of ownership versus lease expense.

Line 494 - A new provider which purchases a facility shall submit a copy of the loan agreement(s), and any other pertinent information concerning the transaction.

Line 495 - Submit a copy of the detailed depreciation schedule with the cost report. Each asset shall be listed with the cost, date of purchase, life, salvage value, accumulated depreciation expense and current depreciation expense. Depreciation must be computed using the STRAIGHT LINE method. If the provider has filed a detailed depreciation schedule with the agency, an annual submission of addition and deletion schedules and a summary of depreciation expense is permissible.

SCHEDULE J - PRIVATE PAY RATES

General: Enter the per diem rates charged to private pay clients during the reporting period according to the effective date, type of accommodation and level of care. Please complete the schedule listing first the current room rates and ending with the rates that were in effect at the beginning of the reporting period.

ICF-MR FINANCIAL AND STATISTICAL REPORT

SEND TO: KANSAS DEPT OF SOCIAL & REHABILITATION SERVICES ICF-MR REIMBURSEMENT MENTAL HEALTH AND RETARDATION SERVICES DOCKING STATE OFFICE BUILDING, 5TH FLOOR 915 S.W. HARRISON TOPEKA, KANSAS 66612		AGENCY USE ONLY	
		(1,2)	
		(3,4)	
		(5,6)	
INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.			
PROVIDER ID NUMBER 4		11. EMPLOYER'S FEDERAL ID NUMBER	
12. PROVIDER NAME		13. FACILITY NAME	
14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP)			
16. ADMINISTRATOR'S NAME		17. PHONE # ( )	18. REPORT PERIOD TO
19. FISCAL YEAR END			
CHECK ONLY ONE 21. EXISTING FACILITY (HISTORICAL)		22. NEW PROVIDER (PROJECTED)	
23. NEW FACILITY (PROJECTED)		24. HISTORICAL R/Y SAME AS PROJECTED PERIOD	
25. HISTORICAL F/Y OVERLAPS PROJECTION PERIOD			
CHECK ONLY ONE 26. SOLE PROPRIETORSHIP		27. PARTNERSHIP	28. CORPORATION-PROFIT
29. CORPORATION-NON PROFIT		30. CITY OWNED	31. COUNTY OWNED
32. OTHER (SPECIFY)			
FACILITY BEDS		(1) BEG OF PERIOD	(2) INCREASE (DECR)
43. MENTALLY RETARDED-DD		(3) DATE OF CHANGE	(4) END OF PERIOD
44. OTHER			
45. TOTAL LICENSED BEDS			
46. TOTAL BED DAYS AVAILABLE			
48. TOTAL CLIENTS DAYS (ALL CLIENTS FROM AU-3902) (4)			
OCCUPANCY PERCENTAGE (AGENCY USE)			
48a TOTAL MEDICAID DAYS		(5)	
DID YOU COMPLETE SCHEDULE J?		YES	NO
50. AGENCY USE ONLY		5003	5004
		5005	
51. IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ATTACH A COPY OF YOUR ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.			
DECLARATION BY OWNER AND PREPARER: I DECLARE THAT I HAVE EXAMINED THIS COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION SET FORTH IN THIS COST REPORT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW. DECLARATION OF PREPARER OTHER THAN OWNER IS BASED ON ALL INFORMATION OF WHICH THE PREPARER HAS ANY KNOWLEDGE.			
YOUR SIGNATURE		TITLE/POSITION	DATE
PREPARER'S SIGNATURE		TITLE/POSITION	DATE
PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)			PHONE # ( )

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Part II

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PROVIDER NUMBER

SCHEDULE A		EXPENSE STATEMENT				
		PER BOOKS OR FEDERAL	PROVIDER	CLIENT RELATED	(AGENCY USE) SRS	(AGENCY USE) ADJ CLIENT REL
ADMINISTRATION COST CENTER	LN#	TAX RETURN (1)	ADJUSTMENTS (2)	EXPENSES (3)	ADJUSTMENTS (4)	EXPENSES (5)
SALARY-ADMINISTRATOR	101					
SALARY--						
CO ADMINISTRATOR	102					
OTHER ADMINISTRATIVE SALARIES	103					
EMPLOYEE BENEFITS	104					
OFFICE SUPPLIES & PRINTING	105					
MANAGEMENT CONSULTANT FEES	106					
OWNER/RELATED PARTY COMPENSATION--						
SCHEDULE B	107					
ALLOCATION OF CENTRAL OFFICE COSTS (SEE INSTRUCTIONS)	108					
PHONE & OTHER COMMUNICATION	109					
TRAVEL	110					
ADVERTISING	111					
LICENSES & DUES	112					
LEGAL, ACCOUNTING & DP	113					
INSURANCE(EXCEPT LIFE)	114					
INTEREST (EXCEPT RE LOANS)	115					
OTHER( )	117					
OTHER( )	118					
TOTAL-ADMINISTRATION	120					

## KANSAS MEDICAID STATE PLAN

PROVIDER NUMBER

SCHEDULE A		EXPENSE STATEMENT				
		PER BOOKS OR FEDERAL TAX RETURN	PROVIDER ADJUSTMENTS	CLIENT RELATED EXPENSES	(AGENCY USE) SRS ADJUSTMENTS	(AGENCY USE) ADJ CLIENT REL EXPENSES
COST CENTER	LN#	(1)	(2)	(3)	(4)	(5)
INTEREST-REAL ESTATE	122					
RENT/LEASE EXPENSE	123					
AMORTIZED LEASEHOLD IMPROVEMENT	124					
DEPRECIATION EXPENSE	125					
TOTAL-OWNERSHIP COST CENTER						
PLANT OPERATING COST CENTER						
REAL & PERSONAL PROPERTY TAX	121					
SALARIES	126					
EMPLOYEE BENEFITS	127					
OWNER/REL PARTY COMP- SCHEDULE B	128					
UTILITIES EXCEPT PHONE	129					
MAINTENANCE & REPAIRS	130					
SUPPLIES	131					
SMALL EQUIPMENT (SEE INSTRUCTIONS)	137					
OTHER( )	138					
TOTAL-PLANT OPERATING COST CENTER	139					

## KANSAS MEDICAID STATE PLAN

PROVIDER NUMBER

SCHEDULE A		EXPENSE STATEMENT				
		PER BOOKS OR FEDERAL TAX RETURN	PROVIDER ADJUSTMENTS	CLIENT RELATED EXPENSES	(AGENCY USE) SRS ADJUSTMENTS	(AGENCY USE) ADJ CLIENT REL EXPENSES
	LN#	(1)	(2)	(3)	(4)	(5)
ROOM & BOARD						
COST CENTER						
ROOM & BOARD						
EMPLOYEE BENEFITS	141					
DIETARY:						
SALARIES	142					
OWNER/RELATED PARTY COMPENSATION--						
SCHEDULE B	143					
DIETARY CONSULTANT	144					
FOOD	145					
SUPPLIES	146					
OTHER( )	148					
LAUNDRY & LINEN:						
SALARIES	149					
LINEN & BEDDING						
MATERIAL	150					
SUPPLIES	151					
OTHER( )	153					
HOUSEKEEPING:						
SALARIES	154					
SUPPLIES	155					
OTHER( )	158					
TOTAL-ROOM & BOARD						
COST CENTER	159					

KANSAS MEDICAID STATE PLAN

PROVIDER NUMBER

SCHEDULE A		EXPENSE STATEMENT				
		PER BOOKS OR FEDERAL TAX RETURN	PROVIDER ADJUSTMENTS	CLIENT RELATED EXPENSES	(AGENCY USE) SRS ADJUSTMENTS	(AGENCY USE) ADJ CLIENT REL EXPENSES
	LN#	(1)	(2)	(3)	(4)	(5)
NURSING:						
REGISTERED NURSE (RN)	161					
LICENSED PRACTICAL NURSE (LPN)/LMHT	162					
OTHER HABIL. PERSNL	163					
EMPLOYEE BENEFITS	164					
OWNER/RELATED PARTY COMP--SCHEDULE B	165					
HABILITATION CONSULTANTS	166					
PURCHASED SERVICES	167					
HABILITATION SUPPLIES	168					
OTHER( )	170					
OTHER CLIENT SERV:						
THERAPY/OTHER SALARIES						
( )	171					
OWNER/RELATED PARTY COMP--SCHEDULE B	172					
CLT ACT/SOCIAL WKR SAL	173					
CLIENT ACT SUPPLIES	174					
OCC THERAPY-CONSULTANT	175					
MED RECORDS-CONSULTANT	176					
PHARMACIST-CONSULTANT	177					
SPEECH THERAPY-CONSLT	178					
PHYSICAL THER-CONSLT	179					
EMPLOYEE ( )	180					
EMPLOYEE TRAINING	181					
CLIENT TRANSPORT	182					
QMRP	183					
OTHER( )	188					
TOTAL-HABILITATION CTR	189					
TOTAL-ALLOWABLE COSTS	190					



EXPENSE RECONCILIATION		PROVIDER NUMBER	
LN#	(1) BOOKS	(2) FED TAX RET	(3) COST REPORT
TOTAL EXPENSES PER BOOKS	231	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
TOTAL EXPENSES PER FEDERAL TAX RETURN	232	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
TOTAL EXPENSES PER COST REPORT (LINE 210, COLUMN 1)	233	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
EXPENSES ON BOOKS OR FEDERAL TAX RET NOT ON COST REPORT			
SPECIFY -	234		XXXXXXXXXXXXXXXXXX
SPECIFY	235		XXXXXXXXXXXXXXXXXX
EXPENSES ON COST REPORT NOT ON BOOKS OR FEDERAL TAX RETURN			
SPECIFY	237	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
SPECIFY	238	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
TOTAL (SHOULD BE EQUAL)	240		

SCHEDULE B STATEMENT OF OWNERS AND RELATED PARTIES

LIST ALL OWNERS OF PROVIDER WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES. IF ANY OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES. ALSO SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES. FOR DEFINITIONS SEE KAR 30-10-200 AND 30-10-209.

NAME, SSN, ADDRESS (CITY & STATE)	(1)	(2)	(3)	(4)	(5)
	%-OWNER- SHIP	%-TIME DEVOTED	TOTAL AMT INCURRED	TITLE, FUNCTION OR DESCRIPTION-TRANSACTION	DISTRIBUTION AMOUNT
1. NAME					
2. SSN					
3. ADDRESS					
1. NAME					
2. SSN					
3. ADDRESS					
1. NAME					
2. SSN					
3. ADDRESS					
1. NAME					
2. SSN					
3. ADDRESS					
TOTALS (SHOULD BE EQUAL)	XXXXXXXXXX	XXXXXXXXXX		XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF 107, 128, 143, 165, 172 & 193.

KANSAS MEDICAID STATE PLAN

PROVIDER NUMBER

SCHEDULE C		SALARIES & WAGES	
LN#	POSITION/TITLE	(16) TOTAL HOURS	(17) TOTAL SALARIES & WAGES
101	ADMINISTRATOR		
102	CO-ADMINISTRATOR		
103	OTHER ADMINISTRATIVE SALARIES		
126	MAINTENANCE		
142	DIETARY		
149	LAUNDRY		
154	HOUSEKEEPING		
161	REGISTERED NURSE		
162	LICENSED PRACTICAL NURSE		
162	LICENSED MENTAL HEALTH TECH		
163	HABILITATION AIDES		
163	MEDICATION AIDES		
163	SPECIFY( )		
163	SPECIFY( )		
171	THERAPY-SPECIFY( )		
171	THERAPY-SPECIFY( )		
171	QMRP		
171	THERAPY-SPECIFY( )		
173	CLIENT ACTIVITIES		
173	SOCIAL WORKER		
	OTHER		
	TOTAL		

REPORT ONLY EMPLOYEE SALARIES- THE OWNER/RELATED PARTY SALARIES ARE REPORTED ON SCHEDULE B. THE TOTALS ON SCHEDULES C & B SHOULD EQUAL THE SALARIES REPORTED ON SCHEDULE A.

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STATEMENT RELATED TO INTEREST

SCHEDULE D ON ALL BONDS, LOANS, NOTES AND MORTGAGES PAYABLE

PROVIDER NUMBER

LN#

301 LENDER'S NAME & ADDRESS:

ITEMS FINANCED

(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
-----------------------------------	----------------------	-----------------------------	-----------------------	------------------------------	-------------------------

302 LENDER'S NAME & ADDRESS:

ITEMS FINANCED:

ORIGINAL DATE AND DURATION	INTEREST RATE	ORIGINAL LOAN AMOUNT	UNPAID BALANCE	TOTAL ANNUAL PAYMENTS	INTEREST EXPENSE
-------------------------------	------------------	-------------------------	-------------------	--------------------------	---------------------

303 LENDER'S NAME & ADDRESS:

ITEMS FINANCED:

ORIGINAL DATE AND DURATION	INTEREST RATE	ORIGINAL LOAN AMOUNT	UNPAID BALANCE	TOTAL ANNUAL PAYMENTS	INTEREST EXPENSE
-------------------------------	------------------	-------------------------	-------------------	--------------------------	---------------------

304 LENDER'S NAME & ADDRESS:

ITEMS FINANCED:

ORIGINAL DATE AND DURATION	INTEREST RATE	ORIGINAL LOAN AMOUNT	UNPAID BALANCE	TOTAL ANNUAL PAYMENTS	INTEREST EXPENSE
-------------------------------	------------------	-------------------------	-------------------	--------------------------	---------------------

305 LENDER'S NAME & ADDRESS:

ITEMS FINANCED:

ORIGINAL DATE AND DURATION	INTEREST RATE	ORIGINAL LOAN AMOUNT	UNPAID BALANCE	TOTAL ANNUAL PAYMENTS	INTEREST EXPENSE
-------------------------------	------------------	-------------------------	-------------------	--------------------------	---------------------

306 LENDER'S NAME & ADDRESS:

ITEMS FINANCED:

ORIGINAL DATE AND DURATION	INTEREST RATE	ORIGINAL LOAN AMOUNT	UNPAID BALANCE	TOTAL ANNUAL PAYMENTS	INTEREST EXPENSE
-------------------------------	------------------	-------------------------	-------------------	--------------------------	---------------------

311 TOTALS |XXXXXXXXXXXXXXXXXXXX|XXXXXXXXXXXXXXXXXXXX|XXXXXXXXXXXXXXXXXXXX|

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF LINES 115 & 122. ENTRIES IN COLUMN 4 MUST AGREE WITH THE BALANCE SHEET. ATTACH A COPY OF LOAN AGREEMENTS AND AMORTIZATION SCHEDULES FOR ALL LOANS OF \$5,000 OR

SCHEDULE E

BALANCE SHEET

PROVIDER NUMBER

BALANCE SHEET SHALL REFLECT THE ASSET, LIABILITY AND RESIDUAL ACCOUNTS OF THIS FACILITY ONLY

	LN	BEGINNING OF PERIOD	END OF PERIOD
	#	(1)	(2)
ASSETS		(3)	(4)
CASH	351	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
ACCOUNTS RECEIVABLE	352	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
LESS: ALLOWANCE FOR DOUBTFUL ACC	353	( )	( )
INVENTORIES & SUPPLIES	354	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
*ALL LOANS TO OFFICERS, OWNERS AND RELATED PARTIES	355	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
*ALL ASSETS NOT REL-CLIENT CARE	356	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
*ASSETS HELD FOR INVESTMENT	357	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
ICF-MR PLANT & EQUIPMENT:			
BUILDING	358	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
LESS: ACCUMULATED DEPRECIATION	359	( )	( )
EQUIPMENT	360	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
LESS: ACCUMULATED DEPRECIATION	361	( )	( )
LEASEHOLD IMPROVEMENTS	362	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
LESS: ACCUMULATED AMORTIZATION	363	( )	( )
LAND	364	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
OTHER( )	365	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
OTHER( )	366	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
TOTAL ASSETS	369	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
LIABILITIES & OWNER'S EQUITY			
ACCOUNTS PAYABLE	371	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
OTHER CURRENT LIABILITIES	372	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
*ALL LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES	373	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
MORTGAGE PAYABLE	374	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
OTHER LONG TERM LIABILITIES	375	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
OWNER'S EQUITY OR FUND BALANCE (LIST APPROPRIATE ACCOUNTS & AMOUNTS--SEE INSTRUCTIONS)			
	377	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
	378	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
	379	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
TOTAL LIAB & OWNER'S EQUITY	380	XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX

\*IF AMOUNTS EXCEED \$10,000 ATTACH SCHEDULE SHOWING DETAILS.

KANSAS MEDICAID STATE PLAN

PROVIDER NUMBER

SCHEDULE F BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION

BALANCE AT BEGINNING OF PERIOD-LINE 377,378 & 379, COLUMN 2.	401	XXXXXXXXXXXXXXXXXXXX
INCREASES:		
REVENUE PER LINE 449, COLUMN 1	402	XXXXXXXXXXXXXXXXXXXX
INVESTMENT BY OWNER	403	XXXXXXXXXXXXXXXXXXXX
TRANSFERS FROM CENTRAL OFFICE	404	XXXXXXXXXXXXXXXXXXXX
COMMON STOCK SOLD	405	XXXXXXXXXXXXXXXXXXXX
OTHER (SPECIFY)	406	XXXXXXXXXXXXXXXXXXXX
OTHER (SPECIFY)	407	XXXXXXXXXXXXXXXXXXXX
TOTAL INCREASES	408	XXXXXXXXXXXXXXXXXXXX
DECREASES:		
EXPENSES PER SCHEDULE A, LINE 210, COLUMN 1	411	XXXXXXXXXXXXXXXXXXXX
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	412	XXXXXXXXXXXXXXXXXXXX
TRANSFERS TO CENTRAL OFFICE	413	XXXXXXXXXXXXXXXXXXXX
DIVIDENDS PAID TO STOCKHOLDERS	414	XXXXXXXXXXXXXXXXXXXX
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	415	XXXXXXXXXXXXXXXXXXXX
OTHER (SPECIFY)	416	XXXXXXXXXXXXXXXXXXXX
OTHER (SPECIFY)	417	XXXXXXXXXXXXXXXXXXXX
TOTAL DECREASES	418	XXXXXXXXXXXXXXXXXXXX ( )
BALANCE AT END OF PERIOD-LINE 377,378 & 379, COLUMN 4.	419	XXXXXXXXXXXXXXXXXXXX

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PROVIDER NUMBER

SCHEDULE G		REVENUE STATEMENT		
	(1) REV PER BOOKS LN#	(2) ADJUSTMENT TO OR FED TAX RETURN	(3) LINE NUMBER EXPENSE ACCOUNTS	OF RELATED EXP
ROUTINE DAILY SERVICE:				
PRIVATE PAY CLIENTS	431			
MEDICAID CLIENTS & PATIENT LIABILITY	432			
NOT APPLICABLE	433			
VETERAN ADMINISTRATION CLIENTS	434			
OTHER CLIENTS (SPECIFY) ( )	435			
PHARMACY-DRUGS & MEDICATIONS	436			
NURSING SUPPLIES SOLD TO PRIVATE PAY CLIENTS	437			
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	438			
BEAUTY/BARBER SHOP	439			
CLIENT PURCHASES	440			
PURCHASE DISCOUNTS, RETURNS & ALLOWANCES	441			
OTHER SUPPLIES SOLD	442			
PROGRAM REIMBURSEMENTS & TAX CREDITS	443			
INVESTMENT/INTEREST INCOME	444			
VENDING MACHINE REVENUE	445			
DAY CARE/TREATMENT INCOME	446			
HEAVY CARE INCOME	447			
OTHER (SPECIFY)	448			
TOTALS	449			XXXXXXXXXXXXXXXXXX

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PROVIDER NUMBER \_\_\_\_\_

SCHEDULE H STATEMENT OF RELATED ICF/MR HOME INFORMATION

461 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ICF-MR FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATIONS)?.....  YES  NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE I.  
 IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
465			
466			
467			
468			
469			
470			
471			
472			
473			
474			
475			
476			
477			
478			
479			
480			

SCHEDULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE			PROVIDER NUMBER
481	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
482	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 493.			
	(1) NAME OF OWNERS OF PHYSICAL FACILITY	(2) % OF OWNERSHIP	(3) DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE IN "NONE"
485			
486			
487			
488			
489			
IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES.			
491	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED.			
492	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
493	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
494	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION?..... (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
495	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?.....			
496	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF NO, SUBMIT COPIES OF DOCUMENTS NOW			

PROVIDER NUMBER

SCHEDULE J

PRIVATE PAY RATES

PROVIDE EACH PRIVATE PAY RATE CHANGE DURING THE FISCAL YEAR REPORTED. PROVIDE ATTACHMENT IF MORE SPACE IS NEEDED. BEGIN WITH CURRENT RATES.

EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
(MOST CURRENT RATES)	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			

1. HAVE YOU AND THE PREPARER SIGNED THE COST REPORT?
2. HAVE YOU COMPLETED ALL THE SCHEDULES?
3. HAVE YOU ATTACHED ALL REQUIRED SCHEDULES AND OTHER DOCUMENTS IN ACCORDANCE WITH THIS REPORT AND ITS INSTRUCTIONS?
4. HAVE YOU SUBMITTED TWO (2) COPIES OF THE COMPLETED COST REPORT AND ONE (1) COPY OF THE AU-3902 (CENSUS SHEETS)?
5. FAILURE TO COMPLETE AND SUBMIT THIS COST REPORT COULD RESULT IN A DELAY IN THE MEDICAID RATE PER

KAS 20.10.21A

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30-10-214 (1)

30-10-214. ICF-MR rates of reimbursement. (a) Rates for ICF's-MR.

(1) The determination of per diem rates shall be made, at least annually by the secretary, on the basis of the cost information supplied by the provider and retained for cost auditing. The cost information for each provider shall be compared with limits established based on the level of care needs of clients to determine the allowable per diem cost.

(2) Ownership allowance shall be determined as follows:

(A) All ICF's-MR initially certified to participate in the medicaid/medikan program prior to July 1, 1991 shall be held to the established ownership allowance.

(B) All ICF's-MR certified on or after July 1, 1991 shall be subject to an absolute cap on ownership costs.

(3) Per diem rates for the following cost centers shall be limited by absolute caps:

(A) The cost center limits shall be based on facility size and level of care. The cost centers and limiting factors are as follows:

(i) Direct service based on facility size and level of care. Direct service consists of the room and board and health care cost centers in the ICF-MR financial and statistical report.

(ii) Administration based on facility size.

(iii) Plant operating shall be based on total allowable costs.

(B) The absolute caps shall be reviewed at least annually for reasonableness based on the reimbursement model and the allowable historical costs. The absolute caps shall be approved by the secretary or a designated official.

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30-10-214 (2)

(4) To establish a per diem rate for each provider by facility size and level of care, a factor for inflation may be added to the allowable per diem cost. The per diem rate shall be based on the lower of the actual allowable cost or the absolute cost center limits. After the rate is established for a provider, a detailed listing of the computation of that rate shall be provided to the provider. The effective date of the rate for existing facilities shall be in accordance with subsection (a) of K.A.R. 30-10-215.

(b) Comparable service rate limitations.

(1) Intermediate care facilities for the mentally retarded and persons with related conditions. The per diem rate for intermediate care for the mentally retarded and persons with related conditions shall not exceed the rate or rates charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR and for the same types of services.

(2) All private pay rate structure changes and the effective dates shall be reported on the uniform cost report.

(3) The agency shall be notified of any private pay rate structure changes within 30 days of the effective date of a new medicaid rate.

(4) Providers shall have a grace period to raise the rate or rates charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR.

(A) The grace period shall end the first day of the third calendar month following notification of a new medicaid/medikan rate.

(B) The notification date is the date typed on the letter which informs the provider of a new medicaid/medikan rate.

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30-10-214 (3)

(C) There shall be no penalty during the grace period if the rate or rates charged to clients not under the medicaid/medikan program are lower than the medicaid/medikan rate.

(D) If the rate or rates charged to clients not under the medicaid/medikan program are lower than rates charged to medicaid/medikan clients after the grace period, the medicaid/medikan rate will be lowered as of the original effective date of the most recent changes.

(c) Rates for new construction or bed additions. The per diem rate or rates for newly constructed ICF's-MR shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-213. No rate shall be paid until an ICF-MR financial and statistical report is received and approved. Limitations established for existing facilities providing the same level of care shall apply. The effective date of the per diem rate shall be in accordance with K.A.R. 30-10-215.

(d) Change of provider.

(1) When a new provider makes no change in the facility, number of beds or operations, the interim payment rate for the first 12 months of operation shall be based on the historical cost data of the previous owner or provider. The new owner or provider shall file a 12-month historical cost report within three months after the end of the first 12 months of operation and another one within three months after the end of the provider's fiscal year established for tax or accounting purposes. The rates determined from these cost reports shall be effective in accordance with K.A.R. 30-10-215.

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30-10-214 (4)

(2) The agency may approve a new rate based on a projected cost report when the care of the clients is certified to be at risk by the Kansas department of health and environment because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

(e) Per diem rates with errors.

(1) When per diem rates, whether based upon projected or historical cost data, are audited by the agency and are found to contain errors, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may be made when a provider has more than one facility involved in settlements.

(2) Per diem rates for providers may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of these per diem rate changes and of the audit findings due to an audit shall be sent to the provider. Retroactive adjustments of rates paid during any projection period shall apply to the same period of time covered by the projected rates.

(3) Providers have 30 days from the date of the audit report cover letter to request an administrative review of the audit adjustments that result in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) Any audit exception imposed on the agency by the department of health and human services due to provider action may be recovered from the provider.

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30-10-214 (5)

(f) Provision of services out-of-state. Rates for clients served out-of-state by certified participants in a medicaid program shall be the rate or rates approved by the agency. All payments made for services provided outside the state of Kansas require prior authorization by the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

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Methods and Standards for Establishing Payment Rates

(ICF's/MR)

Classes of ICF's/MR and Levels of Care

Classes of ICF's/MR shall be either:

- I. State intermediate care facilities for the mentally retarded (class 1)
  - A. All facilities in Class 1 (state intermediate care facilities for the mentally retarded) will be reimbursed with a retrospective payment system. The annual cost reports filed by the state ICF's/MR will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period covered by the cost report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the per diem rates paid during the report period will be multiplied by the paid client days to arrive at the annual settlement.
  - B. The prospective per diem rates will be determined by allowing an inflation factor to be applied to the costs from the previous reporting period.
  - C. An additional factor may be included in determining the prospective rates to account for expected changes in either the costs or resident days during the subsequent fiscal year. The additional projected per diem rate will be added to the prospective per diem rate determined from the last historic cost report on file. The prospective rate will not involve a complete projection of all costs and resident days. A retroactive settlement will be made in accordance with (A) above.

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II. Or, all other ICF's/MR (nonstate) (class 2)

**Levels of Care:**

Annually, the level of functioning is calculated by screening all ICF/MR clients in Kansas using the Developmental Disabilities Profile (DDP), which rates clients on each of three indexes: adaptive functioning, maladaptive behavior, and health needs. Facility converted scores are obtained by performing the following calculations:

1. Each index score is divided by the highest score obtained in Kansas in a given year for the corresponding index.
2. The resulting scores for each index are added together and averaged.
3. The resulting number is multiplied by 100. (Thus, the maximum possible converted score is 300).

Using the above methodology, five levels of facilities are identified based on the following converted DDP scores. Quarterly, the average converted DDP scores will be reviewed. Rate adjustments may be proposed at that time.

<u>LEVELS</u>	<u>CONVERTED DDP SCORES</u>
Level I	175 - and up
Level II	150 - 174.99
Level III	125 - 149.99
Level IV	100 - 124.99
Level V	75 - 99.99

Direct service limits are based on facility size; divided into three groups: above 16 beds; 9 to 16 beds; and 4 to 8 beds; and level of functioning using the chart above.

<u>Facility Size</u>	<u>Level I</u>	<u>Level II</u>	<u>Level III</u>	<u>Level IV</u>	<u>Level V</u>
A. +16 beds	\$120.00	\$114.00	\$108.30	\$ 102.89	\$ 97.74
B. 9-16 beds	\$157.50	\$149.63	\$142.14	\$135.04	\$128.28
C. 4-8 beds	\$213.65	\$202.97	\$192.82	\$ 183.18	\$174.02

Administrative per diem limits are based on the size of the facility, using the same classes as referred to above.

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A.	+16 beds	\$10.00
B.	9-16 beds	\$23.75
C.	4-8 beds	\$28.00

Ownership allowance is established by a property fee system, which is a continuation of the system used previously. The fee has been calculated by analyzing all facility costs, arranging them from high to low, placing them into five groups and adding "value factors":

**VALUE FACTOR**

The per diem reimbursement for facility ownership is based on the historic cost of each facility. The value factor was to reward those with low ownership costs – mortgage interest, rent/lease expense, amortization and depreciation. The value factor calculations for ICFs/MR may be found below and are the same as used in the Nursing Facility program (see Medicaid State Plan transmittal #87-43, effective 10-1-87, approved 2-5-88).

**Calculation methodology for the value factor:**

1) Property Allowance Calculation

The four line items of ownership cost—mortgage interest, rent/lease expense, amortization and depreciation—were added together and divided by client days to arrive at the ownership cost per client day for each provider.

2) Value Factor Calculation

For all providers the property allowances were arrayed based on facility size and percentiles were established. These percentiles became the basis for establishing the property value factor. Five different percentile groupings were developed from each array as follows.

<u>Group No.</u>	<u>Percentile Ranking</u>	<u>Add-on Percent</u>
1	Zero through 25 <sup>th</sup> Percentile	45%
2	26 <sup>th</sup> through 50 <sup>th</sup> Percentile	15%
3	51 <sup>st</sup> through 75 <sup>th</sup> Percentile	7.5%
4	76 <sup>th</sup> through 85 <sup>th</sup> Percentile	5%
5	86 <sup>th</sup> through 100 <sup>th</sup> Percentile	-0-

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Once the percentile groups were established, a weighted average property allowance was calculated for each group. This average property allowance was then multiplied by the add-on percentage to arrive at the property values factor for each group. This add-on percentage is inversely related to the percentile ranking. That is, the lower the percentile ranking, the higher the add-on percentage. The property value factor for each percentile group was then assigned to each provider within that group. See below for the specific values.

GROUP	PERCENTILE FROM	PERCENTILE TO	AMOUNT FROM	AMOUNT TO	AVERAGE ALLOW.	VALUE PERCENT	VALUE FACTOR
-------	-----------------	---------------	-------------	-----------	----------------	---------------	--------------

ICF/MENTALLY RETARDED - LARGE FACILITIES

5	86	100	\$6.26	+	\$6.82	-0-	-0-
4	76	85	\$5.79	\$6.25	\$6.25	5.0	.31
3	51	75	\$3.73	\$5.78	\$5.11	7.5	.38
2	26	50	\$3.17	\$3.72	\$3.61	15.0	.54
1	0	25	-0-	\$3.16	\$2.28	45.01	.03

ICF MENTALLY RETARDED - SMALL & MEDIUM FACILITIES (ie: 4-16 beds)

5	86	100	\$7.88	+	\$14.36	-0-	-0-
4	76	85	\$7.80	\$7.87	\$ 7.87	5.0	.39
3	51	75	\$5.43	\$7.79	\$ 6.46	7.5	.48
2	25	50	\$5.12	\$5.42	\$ 5.29	15.0	.79
1	0	25	\$2.88	\$5.11	\$ 3.87	45.01	.74

Providers will continue with the fee as previously calculated. New facilities have The Ownership Allowance developed from their first actual cost report using the above table to determine the "value factor".

Plant operating costs are reimbursed at actual allowable cost to operate the facility.

RATES AND INFLATION:

PART 1 - SUMMARY

Medicaid rates for Kansas Intermediate Care Facilities for the Mentally Retarded (ICFS/MR) are determined utilizing a prospective, facility-specific rate setting system. Each provider files a historical cost report coincidental with their fiscal year end. Effective January 1, 2005, the per diem rate is determined from base year cost data submitted by the provider. The current base year is the



PART III - INFLATION

The system of applying inflation factors is designed to be equitable to any provider, regardless of their particular fiscal year and cost report filing dates, in setting cost center limitations and determining payment rates. Cost center limitations and new reimbursement rates are determined each year at the beginning of the new payment/limitation period. To accomplish this, two inflation tables are needed – historical and estimated.

The basic philosophy of the inflationary adjustment is to utilize factors that will adjust data from the middle of the cost reporting period of each provider to the middle of the payment period. The purpose for using midpoints for these respective periods is twofold. First, it eliminated the need to recalculate rate for each provider on a monthly basis, and second it is felt that these two points are the most representative point in time to approximate the price level for the entire cost period or payment period.

The historical and estimated inflation factors are based on the Data Resources, Inc., WEFA, National Skilled Nursing Facility Total Market Basket Index (DRI Index). The historical inflation factor for a new rate would be the percent of increase in the DRI from the midpoint of the providers cost period to the latest DRI. The historical inflation factor is a ratio of the DRI at different points in time. Should this ratio of the DRI result in a historical inflation factor less than zero, this historical inflation factor will equal zero.

The annual estimated inflation adjusts from the latest DRI to the midpoint of the payment period.

	HISTORICAL INFLATION	ESTIMATED INFLATION
RATE SCHEDULE: 1/1/05 AND EVERY OCTOBER 1 THEREAFTER	ADJUSTS FROM MID-POINT OF BASE YEAR COST REPORT PERIOD TO LATEST DRI.	ADJUSTS FROM LATEST DRI TO MIDPOINT OF THE PAYMENT PERIOD.

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The inflation factors are applied to all costs except the following:

Allowable Costs:	Exempt from Historical	Exempt from Estimated
Salaries: Administrator	Yes	Yes
Salaries: Co-Administrator	Yes	Yes
Salaries: All other non owner employees	Yes	No
Payroll Taxes	Yes	No
Owner's compensation	Yes	Yes
Interest expenses other than real estate mortgage	Yes	Yes
Real estate taxes	Yes	Yes
Personal property taxes	Yes	Yes

PART IV – EXAMPLES OF METHODOLOGY

<b>BASE YEAR: Provider's FY ending on or before 12/31/03</b>	
<b>PROVIDER COST REPORT PERIOD</b>	
<b>1/1/03 – 12/31/03</b>	
<b>1/1/05 RATE</b>	<b>10/1/05 RATE</b>
<b>PAYMENT PERIOD: 1/1/2005 TO 9/30/05</b> HISTORICAL INFLATION ADJUSTS FROM MID-POINT OF BASE YEAR COST REPORT PERIOD (7/1/03) TO LATEST DRI. ESTIMATED ADJUSTS FROM LATEST DRI TO MIDPOINT OF THE PAYMENT PERIOD (5/15/05).	<b>PAYMENT PERIOD 10/1/05 – 9/30/06</b> HISTORICAL INFLATION ADJUSTS FROM MID-POINT OF BASE YEAR COST REPORT PERIOD (7/1/03) TO LATEST DRI. ESTIMATED ADJUSTS FROM LATEST DRI TO MIDPOINT OF THE PAYMENT PERIOD. (4/1/06)

In this example, the provider has a fiscal year ending 12/31/03. The provider files a cost report covering the period of 1/1/03 through 12/31/03. this period becomes the base year cost reporting period. Effective 1/1/05, the information from the base year 2003 cost report is inflated through the midpoint of the payment period (5/15/05). The costs will be compared to the limits, and a new rate will be established.

The provider continues to file annual cost reports. In this example, the provider's next cost report is for the year ending 12/31/04. Prior to October 1, 2005 (and annually thereafter), the new cost information is inflated and used to determine the

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percentage of cost coverage. The established administration and habilitation cost center limits are re-evaluated and adjusted if necessary. A new rate is established based on the limits and the base year inflation-adjusted costs. October 1 becomes the annual Rate Effective Date.

**B. EXAMPLE – PROVIDER WITH FISCAL YEAR ENDING IN JUNE**

<b>BASE YEAR: Provider's FY ending on or before 12/31/03</b>	
<b>PROVIDER COST REPORT PERIOD</b>	
<b>07/01/02 – 06/30/03</b>	
<b>1/1/05 RATE</b>	<b>10/1/05 RATE</b>
<p><b>PAYMENT PERIOD: 1/1/2005 TO 9/30/05</b>                      HISTORICAL INFLATION ADJUSTS FROM MID-POINT OF BASE YEAR COST REPORT PERIOD (1/1/03) TO LATEST DRI.                      ESTIMATED ADJUSTS FROM LATEST DRI TO MIDPOINT OF THE PAYMENT PERIOD (5/15/05).</p>	<p><b>PAYMENT PERIOD 10/1/05 – 9/30/06</b>                      HISTORICAL INFLATION ADJUSTS FROM MID-POINT OF BASE YEAR COST REPORT PERIOD (1/1/03) TO LATEST DRI.                      ESTIMATED ADJUSTS FROM LATEST DRI TO MIDPOINT OF THE PAYMENT PERIOD (4/1/06).</p>

In this example, the provider has a fiscal year ending 6/30/03. The provider files a cost report covering the period of 7/1/02 through 6/30/03. This period becomes the base year cost reporting period. Effective 1/1/05, the information from the base year cost report is inflated through the midpoint of the payment period (5/15/05). The costs will be compared to the limits, and a new rate will be established.

The provider continues to file annual cost reports. In this example, the provider's next cost reports will be for the years ending 6/30/04 and 6/30/05. Prior to October 1, 2005 (and annually thereafter), the new cost information is inflated and used to determine the percentage of cost coverage. The established administration and habilitation cost center limits are re-evaluated and adjusted if necessary. A new rate is established based on the limits and the base year inflation-adjusted costs. October 1 becomes the annual Rate Effective Date.

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 Instructions  
 State ICF-MR  
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INSTRUCTIONS FOR COMPLETING  
 FINANCIAL REPORTS FOR  
 STATE ICF-MR FACILITIES

PURPOSE

The purpose of this report is to obtain the client-related costs incurred by State ICF's-MR in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The regulations governing the completion of this report and ICF-MR reimbursement can be found in the Kansas Administrative Regulations, Chapter 30, Part 10, Sections 200-226 effective June 1, 1991.

1. One blank Financial Report for State ICF-MR Facilities is sent by Mental Health and Retardation Services (MH&RS) to each state ICF-MR facility in the Medicaid/Medikan Program before the end of the facility's reporting period.
2. Send two copies of the completed Financial Report for State ICF-MR Facilities to the following address:

Mental Health & Retardation Services  
 Department of Social & Rehabilitation Services  
 915 SW Harrison  
 Docking State Office Building, 5th Floor  
 Topeka, KS 66612

Attention: Administrator, ICF-MR Reimbursement

3. All inquires on completion of these forms should be directed to the Administrator, ICF-MR Reimbursement, MH&RS, at (913) 296-3476.

GENERAL

1. COMPLETE THE FORMS ACCURATELY AND LEGIBLY. ANY REPORT THAT IS INCOMPLETE OR IS NOT LEGIBLE WILL BE PROMPTLY RETURNED TO THE PROVIDER. THIS MAY POSTPONE THE RATE EFFECTIVE DATE AND RESULT IN ADDITIONAL PENALTIES FOR LATE FILINGS. KAR 30-10-213 AND 214.
2. ALL TOTALS MUST BE ROUNDED TO THE NEAREST DOLLAR.
3. DO NOT ADD LINES TO THE FORMS. Use "OTHER" lines for patient-related expenses not designated on the Expense Statement, Schedule A.
4. DO NOT CROSS OUT OR RETITLE LINES ON THE FORMS.
5. USE THE ACCRUAL METHOD OF ACCOUNTING IN REPORTING FINANCIAL DATA. Revenues are reported in the period when they are earned, not when they are received, and expenses are reported in the period in which they are incurred, not when they are paid.

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6. ALL COST REPORTS, HISTORICAL OR PROJECTED, MUST BE FOR A PERIOD OF 12 CONSECUTIVE MONTHS. KAR 30-10-213.
7. ALL COST REPORTS MUST BE FILED BY THE LAST DAY OF THE THIRD MONTH FOLLOWING THE END OF THE REPORTING PERIOD (FISCAL YEAR END OR PROJECTION). KAR 30-10-213. The provider may request a 30-day extension of the due date by submitting the request in writing to the address in the submittal instructions within the time period allowed for filing the original cost report. The extension will be granted if the agency determines that the provider has shown good cause. NOTE: IF A COST REPORT IS FILED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES SPECIFIED IN KAR 30-10-213.
8. EACH STATE ICF-MR SHALL MAINTAIN ADEQUATE ACCOUNTING AND/OR STATISTICAL RECORDS. Inadequate recordkeeping is cause for suspension of payments or reduction to the lowest rate(s) for the level(s) of care provided. KAR 30-10-210.
9. REIMBURSEMENT RATES (PER DIEM) FOR STATE ICF-MR. The per diem rate of reimbursement for these facilities is based on the reported costs and client days as adjusted by a desk review of the cost report. An additional factor may be included in determining the prospective rates to account for expected changes in either the costs or resident days during the subsequent fiscal year. Each cost report is also subject to a field audit to arrive at a final settlement for the period the per diem rate was based on the audit cost report.
10. KANSAS ADMINISTRATIVE REGULATIONS. Copies of the regulations governing State ICF-MR reimbursement may be obtained from the address given in the submittal instructions. NOTE: SINCE THE REGULATIONS MAY BE CHANGED ANNUALLY, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM.

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COST REPORT INSTRUCTIONS

COVER PAGE

A) Provider Identification

LINE 11-19 Complete these lines as indicated on the report form.

LINE 21 THROUGH 25: Check Only One Box.

LINE 21. Check if the cost data is for the normal fiscal year of the provider and does not include any portion of a projection period.

LINE 22. Applies to projected cost reports for new providers that are not occupying a newly constructed facility.

LINE 23. Applies only to projected cost reports related to newly constructed facilities. If a provider occupies a newly constructed facility they should check this box. Providers that have increased total beds available through new construction to an existing facility by 10% or more may file a projected cost report and should check this box. KAR 30-10-214.

LINE 24. Applies only to providers filing historical cost reports for the same 12 month period as thur projection year.

LINE 25. Applies to providers in the process of converting from the projection period to their normal fiscal year and the report period includes a portion of the projection period.

LINE 26 THROUGH 32. Check only one box. Check the type of business organization which most accurately describes your facility or explain on line 32.

B) Facility Beds:

LINE 43 THROUGH 45. Enter the number of beds available for each category listed. If a change in the number of beds has occurred during the reporting period, show the increase (of decrease) and the date of the change. Total the categories on line 45.

LINE 46. TOTAL BED DAYS AVAILABLE If the number of beds available throughout the year has not changed, the total number of bed days is computed by multiplying the number of beds times 365 (366 in leap years). If the number of beds changed during the period, compute as shown in the example below.

Assume a home of 20 beds was increased on July 1 to 25 beds, the number of bed days for the period would be determined as follows:

January 1 to June 30	181 days x 20 beds =	3,620 bed days
July 1 to December 31	184 days x 25 beds =	4,600 bed days
		<u>8,220</u> bed days for period

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LINE 48. TOTAL CLIENT DAYS. The total number of client days is the actual days of care rendered to clients for the period. The day of admission is counted but not the day of discharge or death. Paid reserve days must be included as client days. See K.A.R. 30-10-200. The total client days must agree with the 12-month total of client days as submitted on form AU 3902.

OCCUPANCY PERCENTAGE: Agency staff will determine this percentage.

TOTAL MEDICAID/MEDIKAN DAYS: Enter the total number of Medicaid/Medikan days reported on the Au 3902's. Partial as well as full paid days must be included.

LINE 50. AGENCY USE ONLY.

LINE 51. If the provider is a public held entity, provide annual reports and Form 10-K.

C) Declaration by Owner and Preparer: The cost report is not considered complete unless signed by a representative of the facility (i.e. owner, officer, administrator, etc.) and the preparer. PLEASE READ DECLARATION STATEMENT.

SCHEDULE A - EXPENSE STATEMENT

ATTACH A COPY OF THE SUMMARY PAGE OF THE BUDGET.

Report expenses in the AMOUNT column. List the source of the expense in the SOURCE column. The expenses should be referenced to the actual expense column of the budget where possible. Please use the following abbreviations:

O.C. = Object Code  
P.C. = Program Code  
S.C. = Source Code

If it is not possible to refer directly to the budget, reference to a workpaper and attach a copy.

Fiscal Year      Budget. Fill in the fiscal year of the budget referred to in the Source column.

Line 1 - Total Budget Expenditures. Report total expenditures from Line 40 of the budget summary page.

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General Adjustments. Report adjustments used to derive Total Medicaid Expenditures from Total Budget Expenditures.

Lines 2, 3, & 4. Report amounts from the most current Central Office Allocation memo prepared by the Fiscal Management Section of Mental Health & Retardation Services. Attach a copy to the cost report.

Line 5 - Depreciation Expense. Report the amount shown on the Agency Total Line in the Current depreciation (CUR-DEPR) column of the inventory depreciation. If adjustments are required to current depreciation, attach a schedule detailing the adjustment.

Lines 6, 7, & 8. Report any other additions to the Total Budget Expenditures (Example: Laundry expense allocation from Topeka State Hospital to Kansas Neurological Institute).

Lines 11, 12, & 13. Report the amounts from the budget as noted on the cost report.

Lines 14, 15, & 16. Report any other reductions to the Total Budget Expenditures (Example: Meals charged to TSH by KNI).

Line 20 - Total Medicaid Expenditures. Total of Line 1 plus Lines 2 through 8 and less Lines 11 through 16.

Non-Patient Related Expenses. Report non-client related expenses less any revenue offsets.

Line 21 - SRS Area Office. Report any costs associated with the maintenance of a SRS Area Office at the facility.

Line 22 - Sheltered Living. Report any costs associated with the Sheltered Living Program.

Lines 23, 24, & 25. Report any other non-client related expenses.

Line 30 - Client Related Expenditures. Line 20 less Lines 21 through 25.

Line 30A - Client Related Expenditures. Move the amount on Line 30 to the top of Page 2.

Revenues. Report revenues from the General Fee Fund on the appropriate line in the Total Revenue column. Common types of revenue have been listed and their source codes shown. Specify other types on the blank lines and list their sources. If more lines are needed use one blank line as a summary and attach a sheet listing the revenues.

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Report the revenue to be offset in the Revenue Offset Column. The revenue offset is not to exceed the related expense. For example, the facility receives \$1,000 rental income and the expenses related to this income (supplies, repairs, utilities, etc.) total \$750. Therefore report \$1000 in the Total Revenue column and \$750 in the Revenue Offset column. Do not report a revenue offset for expenses disallowed as non-client related. For example, rental revenue received from the SRS Area Office is not to be offset as the cost of maintaining the area office is disallowed as non-client related on Line 21.

Line 49 - Total Revenue Offset. Report the total of the Revenue Offset column.

Line 50 - Net Client Related Expenditures. Line 30A less Line 49.

Non-Reimbursable Expenses. Report non-reimbursable expenses.

Line 51 - Foster Grandparent Program. Report the cost of the Federal portion of the Foster Grandparent Program.

Line 52 - Clothing for Clients. Report the cost of clothing purchased for clients.

Line 53, 54, & 55. Report the percentage of the Barber's Cosmetologist's, and Chaplin's time devoted to non-reimbursable activities. Report that portion of their salaries and fringe in the AMOUNT column.

Line 56 - Religious Items and Services. Report the cost of religious items and services.

Lines 57 & 58. Report any other non-reimbursable expense.

Line 60 - Net Reimbursable Expenditures. Record the total of Line 50 less Lines 51 through 58.

Education Expenses. The education portion of the following expenses are non-reimbursable.

Line 61 - Special Education Contracts. Report cost of special education contracts.

Line 62 - Special Education Non-Contractual. Report non-contractual special education costs.

Line 63, 64, 65, 66, & 67. Calculate the amount to be reported by determining the percentage of the educational square footage to total square footage and reporting this percentage of these expenses. Attach a copy of the workpaper.

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Line 68 - Telephone. Calculate the amount to be reported by determining the percentage of educational telephones to total telephones and reporting this percentage of the telephone expense.

Line 69. Report any other educational expenses. Attach a schedule if additional lines are needed.

Line 70 - Total Education Expenses. Record the total of lines 61 through 69.

Line 75 - Net Non-Educational Expenditure. Line 60 less Line 70.

Line 75A - Net Non-Educational Expenditures. Move the amount on Line 75 to the top of Page 3.

Lines 76, 77, & 78. Report any other adjustments needed.

Line 80 - Total Allowable Expenditures. Line 75A plus or minus Lines 76 through 78.

SRS Office of Audit Services Adjustments. DO NOT WRITE BELOW LINE 80. This section is reserved for AGENCY USE ONLY.

SCHEDULE B - SALARIES & WAGES

Line 1 - Total Salaries and Wages. Report the amount of Object Code 100 from the budget summary page.

Adjustments. Report the amount of salaries and fringe for each of the programs or employees listed. Use the blank lines for any other adjustments to Total Salaries and Wages.

Line 10 - Total Allowable Salaries and Wages. Record the total of Line 1 less Lines 2 through 9.

SRS Audit Section Adjustments. DO NOT WRITE BELOW LINE 10. This section is reserved for AGENCY USE ONLY.



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Provider No. \_\_\_\_\_

SCHEDULE A

Fiscal Year _____ Budget	AMOUNT	SOURCE
1. Total Budget Expenditures	_____	DA406R Line 40
<u>General Adjustments</u>		
<u>Additions:</u>		
2. Allocation of Agency 628	_____	_____
3. Mental Hospital Training Fund	_____	_____
4. Department of Administration	_____	_____
5. Depreciation Expense	_____	_____
6. Other: _____	_____	_____
7. Other: _____	_____	_____
8. Other: _____	_____	_____
<u>Subtractions:</u>		
11. Capital Improvements	( _____ )	DA406R Line 37
12. Capital Outlays	( _____ )	DA406R O.C. 400
13. Non-expense Items	( _____ )	DA406R O.C. 700
14. Other: _____	( _____ )	_____
15. Other: _____	( _____ )	_____
16. Other: _____	( _____ )	_____
20. Total Medicaid Expenditures	_____	
<u>Non-Patient Related Expenditures</u>		
21. SRS Area Office	( _____ )	_____
22. Sheltered Living	( _____ )	_____
23. _____	( _____ )	_____
24. _____	( _____ )	_____
25. _____	( _____ )	_____
30. Patient Related Expenditures	_____	

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30A. Patient Related Expenditures

Revenue

	Total Revenue	Revenue Offset	
31. Educ. & Librarian	_____	(_____)	DA404R S.C. 2050
32. Care & Hospital	_____	(_____)	DA404R S.C. 2060
33. Sale of Equipment	_____	(_____)	DA404R S.C. 2260
34. Meals & Food	_____	(_____)	DA404R S.C. 2270
35. State Build Space	_____	(_____)	DA404R S.C. 3130
36. Curr Exp Recovery	_____	(_____)	DA404R S.C. 6211
37. Prior Exp Recovery	_____	(_____)	DA404R S.C. 6901
38. _____	_____	(_____)	_____
39. _____	_____	(_____)	_____
40. _____	_____	(_____)	_____
41. _____	_____	(_____)	_____
49. Total Revenue Offset		(_____)	

50. Net Patient Related Expenditures

Non-Reimbursable Expenses

51. Foster Grandparent Program		(_____)	_____
52. Clothing for Residents		(_____)	_____
53. Barber Salary & Fringe	(____%)	(_____)	_____
54. Cosmetologist Salary & Fringe	(____%)	(_____)	_____
55. Chaplin Salary & Fringe	(____%)	(_____)	_____
56. Religious Items and Services		(_____)	_____
57. _____		(_____)	_____
58. _____		(_____)	_____

60. Net Reimbursable Expenditures

Education Expense

61. Special Educ Contracts	(_____)	_____
62. Special Educ Non-contract	(_____)	_____
63. Maint. Salary & Benefits	(_____)	_____
64. Utilities	(_____)	_____
65. Repair & Maintenance	(_____)	_____
66. Maintenance Supplies	(_____)	_____
67. Depreciation	(_____)	_____
68. Telephone	(_____)	_____
69. _____	(_____)	_____
70. Total Education Expense		(_____)

75. Net Non-Educational Expenditures

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75A. Net Non-Educational Expenditures \_\_\_\_\_

Other

76. \_\_\_\_\_

77. \_\_\_\_\_

78. \_\_\_\_\_

80. Total Allowable Expenditures \_\_\_\_\_

AGENCY USE ONLY

SRS Audit Section Adjustments

81. \_\_\_\_\_

82. \_\_\_\_\_

83. \_\_\_\_\_

84. \_\_\_\_\_

85. \_\_\_\_\_

86. \_\_\_\_\_

89. Total SRS Adjustments \_\_\_\_\_

90. Total Adjusted Allowable Expenditures \_\_\_\_\_

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Schedule B

	<u>AMOUNT</u>	<u>SOURCE</u>
1. Total Salaries and Wages	_____	DA406R O.C. 100
<u>Adjustments</u>		
2. Foster Grandparent Program	(_____)	_____
3. Barber	(_____)	_____
4. Cosmetologist	(_____)	_____
5. Chaplin	(_____)	_____
6. Education	(_____)	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. Total Allowable Salaries & Wages	_____	_____

AGENCY USE ONLY

SRS Audit Section Adjustment

11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____
19. Total SRS Adjustments	_____	_____
20. Total Adjusted Salaries & Wages	_____	_____

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**LICENSURE**

Cross References to Related Sections:

Reporting abuse or neglect of residents of adult care homes and certain medical care facilities, see K.S.A. 39-1401 et seq.

**39-923. Definitions.** (a) As used in this act:

(1) "Adult care home" means any skilled nursing home, intermediate nursing care home, intermediate personal care home, one-bed adult care home and two-bed adult care home and any boarding care home, all of which classifications of adult care homes are required to be licensed by the secretary of health and environment. Adult care home does not mean adult family home.

(2) "Skilled nursing home" means any place or facility operating for not less than 24 hours in any week and caring for three or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.

(3) "Intermediate nursing care home" means any place or facility operating for not less than 24 hours in any week and caring for three or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board and supervised nursing care and treatment is provided, and which place or facility is staffed to provide at least eight hours a day for at least five days a week licensed nursing personnel plus additional staff and is maintained and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care or skilled nursing care but who require supervised nursing care.

(4) "Intermediate personal care home" means any place or facility operating for not less than 24 hours in any week and caring for three or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board, personal care and treatment or simple nursing care is provided, and which place or facility is staffed, maintained and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care, skilled nursing home care or moderate nursing care but who require domiciliary care and simple nursing care.

(5) "One-bed adult care home" and "two-bed adult care home" means any place or facility which place or facility may be a private residence and which place or facility is operating for not less than 24 hours in any week and caring for one or two individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board, personal care and treatment and skilled nursing care, supervised nursing care or simple nursing care is provided by the adult care home, and which place or facility is staffed, maintained and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care but who require domiciliary care and skilled nursing care, supervised nursing care or simple nursing care provided by the adult care home. When the home's capabilities are questioned in writing, the licensing agency shall determine according to its rules and regulations if any restriction will be placed on the care the home will give residents.

(6) "Boarding care home" means any place or facility operating for not less than 24 hours in any week and caring for three or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves

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and for whom reception, accommodation, board and supervision is provided and which place or facility is staffed, maintained and equipped primarily to provide shelter to residents who require some supervision, but who are ambulatory and essentially capable of managing their own care and affairs.

(7) "Place or facility" means a building or any one or more complete floors of a building, or any one or more complete wings of a building, or any one or more complete wings and one or more complete floors of a building, and the term "place or facility" may include multiple buildings.

(8) "Skilled nursing care" means services commonly performed by or under the immediate supervision of a registered professional nurse and additional licensed nursing personnel for individuals requiring 24 hour a day care by licensed nursing personnel including: Acts of observation, care and counsel of the ill, injured or infirm; the administration of medications and treatments as prescribed by a licensed physician or dentist; and other nursing functions requiring substantial specialized judgment and skill based on the knowledge and application of scientific principles.

(9) "Supervised nursing care" means services commonly performed by or under the immediate supervision of licensed nursing personnel at least eight hours a day for at least five days a week including: Acts of observation, care and counsel of the ill, injured or infirm; the administration of medications and treatments as prescribed by a licensed physician or dentist; and other selected functions requiring specialized judgment and certain skills based on the knowledge of scientific principles.

(10) "Simple nursing care" means selected acts in the care of the ill, injured or infirm requiring certain knowledge and specialized skills but not requiring the substantial specialized skills, judgment and knowledge of licensed nursing personnel.

(11) "Resident" means all individuals kept, cared for, treated, boarded or otherwise accommodated in any adult care home.

(12) "Person" means any individual, firm, partnership, corporation, company, association or joint stock association, and the legal successor thereof.

(13) "Operate an adult care home" means to own, lease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word "own" and the word "lease" shall not include hospital districts, cities and counties which hold title to an adult care home purchased or constructed through the sale of bonds.

(14) "Licensing agency" means the secretary of health and environment.

(b) The term "adult care home" shall not include institutions operated by federal or state governments, hospitals or institutions for the treatment and care of psychiatric patients, boarding homes for children under the age of 16 years, day nurseries, child caring institutions, maternity homes, hotels or offices of physicians.

(c) The licensing agency may by rule and regulation change the name of the different classes of homes when necessary to avoid confusion in terminology and the agency may further amend, substitute, change and in a manner consistent with the definitions established in this section, further define and identify the specific acts and services which shall fall within the respective categories of facilities so long as the above categories for adult care homes are used as guidelines to define and identify the specific acts.

History: L. 1961, ch. 231, § 1; L. 1967, ch. 246, § 1; L. 1972, ch. 171, § 1; L. 1975, ch. 462, § 39; L. 1978, ch. 161, § 11; L. 1982, ch. 189, § 1; L. 1983, ch. 146, § 1; April 21.

Cross References to Related Sections:

Adult care home lawsuit settlement fund, see 75-5341, 75-5342.

Research and Practice Aids:

Social Security and Public Welfare § 6.  
C.J.S. Social Security and Public Welfare § 10.

#### CASE ANNOTATIONS

1. Mentioned; action by nursing homes for recovery of reasonable charges for services rendered. *Seneca Nursing Home v. Kansas State Bd. of Social Well.*, 490 F.2d 1324, 1330, 1333.

2. Licensure and certification denied; appellate court review limited as district court; broader review dilutes advantage of fact-finding by specialized agency. *Boswell, Inc. d/b/a Reno County Adult Care Home v. Harkins*, 230 K. 610, 611, 640 P.2d 1202 (1982).

3. Provisions for licensure of adult care homes not unlawful delegation of legislative authority; not vague and indefinite. *Boswell, Inc. d/b/a Broadacres v. Harkins*, 230 K. 738, 740, 741, 640 P.2d 1208 (1982).

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**39-924. Purpose of act.** The purpose of this act is the development, establishment, and enforcement of standards (1) for the care, treatment, health, safety, welfare and comfort of individuals in adult care homes licensed by the secretary of health and environment and (2) for the construction, general hygiene, maintenance and operation of said adult care homes, which, in the light of advancing knowledge, will promote safe and adequate accommodation, care and treatment of such individuals in adult care homes.

History: L. 1961, ch. 231, § 2; L. 1972, ch. 171, § 2; L. 1975, ch. 462, § 40; July 1.

CASE ANNOTATIONS

1. Denial of licensure for repeated violations not arbitrary, reasonable relation to lawful purpose of act. *Boswell, Inc. d/b/a Reno County Adult Care Home v. Harkins*, 230 K. 610, 615, 640 P.2d 1202 (1982).

2. Statutory provisions not unlawful delegation of legislative authority; not vague and indefinite. *Boswell, Inc. d/b/a Broadacres v. Harkins*, 230 K. 738, 741, 640 P.2d 1206 (1982).

**39-925. Administration of act.** The administration of this act shall be under the secretary of health and environment as the licensing agency in conjunction with the state fire marshal, and shall have the assistance of the county, city-county or multi-county health departments, local fire and safety authorities and other agencies of government in this state.

History: L. 1961, ch. 231, § 3; L. 1975, ch. 462, § 41; L. 1980, ch. 182, § 10; July 1.

**39-926. License required to operate** and compliance with regulations. It shall be unlawful for any person or persons acting individually or severally to operate an adult care home within this state except upon license had and obtained for that purpose from the secretary of health and environment as licensing agency upon application made for as provided in this act, and compliance with the requirements, standards, and regulations, promulgated under provisions.

History: L. 1961, ch. 231, § 4; L. 1972, ch. 171, § 3; L. 1975, ch. 462, § 42; L. 1978, ch. 171, § 11; July 1.

and Practice Aids:  
§ 3.  
§ 5.

CASE ANNOTATIONS

1. Agency specifically authorized to establish standards for licensure and operation; no unlawful delegation of authority. *Boswell, Inc. d/b/a Broadacres v. Harkins*, 230 K. 738, 741, 640 P.2d 1206 (1982).

**39-926a. Limitation on number of persons licensed to operate adult care home;** application of section; section supplemental to adult care home licensure act. (a) Except as otherwise provided in this section, no more than three different persons shall be licensed to operate any one adult care home under the adult care home licensure act, and no license to operate any one adult care home shall be issued under that act to more than three different persons. The provisions of this section shall not apply to any license to operate an adult care home which is in effect on the effective date of this act and which is issued to more than three different persons, or the renewal of any such license, unless subsequent to the effective date of this act three or fewer persons operate the adult care home or the license to operate the adult care home is denied or revoked.

(b) This section shall be part of and supplemental to the adult care home licensure act.

History: L. 1983, ch. 141, § 1; April 21.

**39-927. Application for license;** contents; application for license to operate new intermediate nursing care home for the mentally retarded; limitations. An application for a license to operate an adult care home shall be made in writing to the licensing agency upon forms provided by it and shall be in such form and shall contain such information as the licensing agency shall require, which may include affirmative evidence of the applicant's ability to comply with such reasonable standards and rules and regulations as are adopted under the provisions of this act. The application shall be signed by the person or persons seeking to operate an adult care home, as specified by the licensing agency, or by a duly authorized agent of any person so specified. Any nonprofit corporation operating an intermediate nursing care home for the mentally retarded which, on the effective date of this act, includes more than one residential building located on one site or on contiguous sites may apply for a

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license to operate a new intermediate nursing care home for the mentally retarded which includes more than one residential building located on one site or on contiguous sites and may apply for one license for each residential building located on the new site, except that total resident population at any such location shall not exceed 75 residents.

History: L. 1961, ch. 231, § 5; L. 1972, ch. 171, § 4; L. 1976, ch. 280, § 21; L. 1982, ch. 189, § 2; L. 1985, ch. 150, § 1; July 1.

**39-928.** Issuance of license, when; inspections and investigations; reports; time license effective; nontransferable; display; contents of license. Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. The licensing agency, the state fire marshal, and the county, city-county or multicounty health departments or their designated representatives shall make such inspections and investigations as are necessary to determine the conditions existing in each case and a written report of such inspections and investigations and the recommendations of the state fire marshal and the county, city-county or multicounty health department or their authorized agents shall be filed with the licensing agency. The licensing agency and the state fire marshal may designate and use county, city-county or multicounty health departments and local fire and safety authorities as their agents in making such inspections and investigations as are deemed necessary or advisable. Such local authorities are hereby authorized, empowered and directed to perform such duties as are designated. A copy of any inspection reports required by this section shall be furnished to the applicant.

A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee. Each license shall be issued only for the premises and per-

sons named in the application and shall not be transferable or assignable. It shall be posted in a conspicuous place in the adult care home. If the annual report is not so filed and annual fee is not paid, such license is automatically canceled. Any license granted under the provisions of this act shall state the type of facility for which license is granted, number of residents for which granted, the person or persons to whom granted, the date and such additional information and special limitations as are deemed advisable by the licensing agency.

History: L. 1961, ch. 231, § 6; L. 1972, ch. 171, § 5; L. 1980, ch. 182, § 11; L. 1989, ch. 126, § 1; July 1.

CASE ANNOTATIONS

1. Cited, preemption of state law and regulations by federal law and regulations regarding Medicaid reimbursement examined *Americare Properties, Inc v. S.R.S.*, 241 K. 607, 610, 738 P.2d 450 (1987).

**39-929.** Provisional license, approval; terms; extension. A provisional license may be issued to any adult care home, the facilities of which are temporarily unable to conform to all the standards, requirements, rules and regulations established under the provisions of this act: *Provided, however,* That the issuance of such provisional license shall be approved by the state fire marshal. A provisional license may be issued to provide time to make necessary corrections for not more than six (6) months. One additional successive six-month provisional license may be granted at the discretion of the licensing agency. A change of ownership during the provisional licensing period will not extend the time for the requirements to be met that were the basis for the provisional license nor entitle the new owner to an additional provisional license.

History: L. 1961, ch. 231, § 7; L. 1972, ch. 171, § 6; July 1.

CASE ANNOTATIONS

1. Past agency error in granting provisional licenses does not abrogate enforcement of section; denial of licensure is not denial of equal protection of law. *Boswell, Inc. d/b/a Reno County Adult Care Home v. Harkins*, 230 K. 610, 614, 640 P.2d 1202 (1982).

**39-930.** License fee; disposition. The fee for license to operate an adult care home shall be a base amount plus an additional amount for each bed of such home which shall be paid

to the secretary of health and environment before the license is issued. The fee shall be fixed by rules and regulations of the secretary of health and environment. The fee shall be deposited in the state treasury and credited to the state general fund unless the evaluation and inspection was made by a county, city-county or multicounty health department at the direction of the secretary of health and environment and the papers required are completed and filed with the secretary, then 40% of the fee collected shall be forwarded to such county, city-county or multicounty health department. If a facility has a change of administrator after the commencement of the licensing period, the fee shall be \$15 and shall be deposited in the state treasury and credited to the state general fund.

History: L. 1961, ch. 231, § 8; L. 1972, ch. 171, § 7; L. 1975, ch. 462, § 43; L. 1980, ch. 182, § 12; L. 1982, ch. 189, § 3; L. 1983, ch. 286, § 1; L. 1988, ch. 145, § 1; July 1.

**39-931.** Denial, suspension or revocation of license: notice; hearing; appeal. Whenever the licensing agency finds a substantial failure to comply with the requirements, standards or rules and regulations established under this act or that a receiver has been appointed under K.S.A. 39-958 and amendments thereto, it shall make an order denying, suspending or revoking the license after notice and a hearing in accordance with the provisions of the Kansas administrative procedure act.

Any applicant or licensee who is aggrieved by the order may appeal such order in accordance with the provisions of the act for judicial review and civil enforcement of agency actions.

History: L. 1961, ch. 231, § 9; L. 1975, ch. 462, § 44; L. 1978, ch. 162, § 12; L. 1982, ch. 258, § 1; L. 1983, ch. 147, § 1; L. 1984, ch. 313, § 65; July 1, 1985.

**Law Review and Bar Journal References:**

"Administrative Law: The Kansas Commission on Civil Rights—True De Novo Review Arrives." Samuel D. Ogelby, 16 W.L.J. 161, 163 (1976).

"Judicial Review of Administrative Action—Kansas Perspectives." David L. Ryan, 19 W.L.J. 423, 433 (1980).

**CASE ANNOTATIONS**

1. Review by appellate court limited as district courts; broader review dilutes advantage of fact-finding by specialized agency. *Boswell, Inc. d/b/a Reno County Adult Care Home v. Harkins*, 230 K. 610, 612, 614, 617, 640 P.2d 1202 (1982).
2. De novo review of administrative proceedings denied; court review limited in scope. *Boswell, Inc. d/b/a Broadacres v. Harkins*, 230 K. 738, 740, 640 P.2d 1208 (1982).

**39-931a.** Denial, suspension or revocation of license; grounds; "person" defined. (a) As used in this section the term "person" means any person who is an applicant for a license to operate an adult care home or who is the licensee of an adult care home and who has any direct or indirect ownership interest of twenty-five percent (25%) or more in an adult care home or who is the owner, in whole or in part, of any mortgage, deed of trust, note or other obligation secured, in whole or in part, by such facility or any of the property or assets of such facility, or who, if the facility is organized as a corporation, is an officer or director of the corporation, or who, if the facility is organized as a partnership, is a partner.

(b) Pursuant to K.S.A. 39-931, the licensing agency may deny a license to any

**39-932.** Adoption and enforcement of rules, regulations and standards. The licensing agency shall adopt, amend, promulgate and enforce such rules, regulations and standards as may be deemed practicable, reasonable and necessary with respect to all adult care homes, to be licensed hereunder and as may be designed to further the accomplishment of the purpose of this law in promoting safe, proper and adequate treatment and care of individuals in adult care homes in the interest of public health, safety and welfare. Such rules and regulations may prescribe minimum standards and requirements relating to the location, building, construction, size, equipment and facilities of adult care homes, the number and kind of residents allowed, the types of care offered, the records to be kept, the kind and frequency of reports and inventories to be made, and may

generally establish such requirements as may be deemed necessary to protect the health, safety, hygiene, welfare and comfort of the residents.

Adult care homes which are in operation at the time of promulgation of any applicable rules and regulations or minimum standards under this act shall be given a reasonable time, under the particular circumstances not to exceed twelve (12) months from the date of such promulgation, within which to comply with such rules and regulations and minimum standards. The licensing agency may further establish by regulation a system whereby it may, on the basis of the investigations and evaluations herein provided for, uniformly rate adult care homes in terms of the quality and quantity of services and facilities provided.

History: L. 1961, ch. 231, § 10; L. 1972, ch. 171, § 8, July 1.

**39-932a.** Adult care homes in less than an entire building. The licensing agency shall provide by rules and regulations for the licensing of adult care homes in any one or more complete floors of a building, or any one or more complete wings of a building, or any one or more complete wings and one or more complete floors of a building, in addition to licensing of adult care homes in entire buildings. In the case of adult care homes in less than an entire building, the licensing agency shall prescribe acceptable use and occupancy of the balance of such building, and shall prohibit those uses and occupancies which are deemed to be contrary to the public interest.

History: L. 1967, ch. 246, § 2; April 21.

**39-933.** Inspections and investigations; regulations for changes in facilities. The licensing agency shall make or cause to be made by the county, city-county or multicounty health departments such inspections and investigations as it deems necessary. The licensing agency may prescribe by regulation that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall submit plans and specifications therefor, before commencing such alterations, additions or new construction, to the licensing agency for preliminary inspection and approval or recommenda-

tions with respect to compliance with the regulations and standards herein authorized. Necessary conferences and consultations may be provided.

History: L. 1961, ch. 231, § 11; L. 1960, ch. 182, § 13; July 1.

Research and Practice Aids:

Asylums—3.

C.J.S. Asylums § 5.

**39-934.** Certain information confidential. Information received by the licensing agency through filed reports, inspections, or as otherwise authorized under this law, shall not be disclosed publicly in such manner as to identify individuals.

History: L. 1961, ch. 231, § 12; L. 1972, ch. 171, § 9; L. 1975, ch. 238, § 1; July 1.

Revisor's Note:

Exclusion of media from hearings, see *Kansas Benchbook*, Kansas Judicial Council, p. 226b

**39-935.** Inspections; reporting; access to premises; exit interviews; unannounced inspections; inspection reports, posting and access. Inspections shall be made and reported in writing by the authorized agents and representatives of the licensing agency and state fire marshal, and of the county, city-county and multicounty health departments as often and in the manner and form prescribed by the rules and regulations promulgated under the provisions of this act. Access shall be given to the premises of any adult care home at any time upon presenting adequate identification to carry out the requirements of this section and the provisions and purposes of this act, and failure to provide such access shall constitute grounds for denial or revocation of license. A copy of any inspection reports required by this section shall be furnished to the applicant, except that a copy of the preliminary inspection report signed jointly by a representative of the adult care home and the inspector shall be left with the applicant when an inspection under this section is completed. This preliminary inspection report shall constitute the final record of deficiencies assessed against the adult care home during the inspection, all deficiencies shall be specifically listed and no additional deficiencies based upon the data developed at that time shall be assessed at a later time. An exit interview shall be conducted in conjunction with the joint signing of the preliminary inspection report.

The authorized agents and representatives of the licensing agency shall conduct at least one unannounced inspection of each adult care home within 15 months of any previous inspection for the purpose of determining whether the adult care home is complying with applicable statutes and rules and regulations relating to the health and safety of the residents of the adult care home. The statewide average interval between inspections shall not exceed 12 months.

Every adult care home shall post in a conspicuous place a notice indicating that the most recent inspection report and related documents may be examined in the office of the administrator of the adult care home. Upon request, every adult care home shall provide to any person a copy of the most recent inspection report and related documents, provided the person requesting such report agrees to pay a reasonable charge to cover copying costs.

History: L. 1961, ch. 231, § 13; L. 1972, ch. 171, § 10; L. 1977, ch. 152, § 1; L. 1978, ch. 162, § 13; L. 1980, ch. 182, § 14; L. 1989, ch. 126, § 2; July 1.

Review and Bar Journal References:  
"Nursing Home Tort Litigation," Michael E. Callen,  
X, No. 1, J.K.T.L.A. 17 (1985).

§-836. Statement on admission; qualified personnel; education and training of unlicensed personnel; requirements of licensing agency; rules and regulations; examination and examination fee; supplier of medication; limitations on involuntary transfer or discharge of resident; effect of reliance upon spiritual means or prayer for healing by resident. (a) The presence of each resident in an adult care home shall be covered by a statement provided at the time of admission, or for thereto, setting forth the general responsibilities and services and daily or monthly charges for such responsibilities and services. Each resident shall be provided with a copy of such statement, with a copy going to any individual responsible for payment of such charges and the adult care home shall keep a copy of such statement in the resident's file. Such statement shall be construed to relieve the adult care home of any requirement or obligation imposed upon it by law or by any requirement, standard or rule and regulation adopted pursuant thereto.

(b) A qualified person or persons shall be in attendance at all times upon residents receiving accommodation, board, care, training or treatment in adult care homes. The licensing

agency may establish necessary standards and rules and regulations prescribing the number, qualifications, training, standards of conduct and integrity for such qualified person or persons attendant upon the residents.

(c) (1) Unlicensed employees of an adult care home who provide direct, individual care to residents under the supervision of qualified personnel and who do not administer medications to residents shall not be required by the licensing agency to complete a course of education or training or to successfully complete an examination as a condition of employment or continued employment by an adult care home during their first 90 days of employment.

(2) The licensing agency shall require unlicensed employees of an adult care home employed on and after the effective date of this act who provide direct, individual care to residents and who do not administer medications to residents and who have not completed a course of education and training relating to resident care and treatment approved by the licensing agency or are not participating in such a course on the effective date of this act to complete successfully 40 hours of training in basic resident care skills. Any unlicensed person who has not completed 40 hours of training relating to resident care and treatment approved by the licensing agency shall not provide direct, individual care to residents. The 40 hours of training shall be supervised by a registered professional nurse and the content and administration thereof shall comply with rules and regulations adopted by the licensing agency. The 40 hours of training may be prepared and administered by an adult care home or by any other qualified person and may be conducted on the premises of the adult care home. The 40 hours of training required in this section shall be a part of any course of education and training required by the licensing agency under subsection (c)(3).

(3) The licensing agency may require unlicensed employees of an adult care home who provide direct, individual care to residents and who do not administer medications to residents after 90 days of employment to successfully complete an approved course of instruction and an examination relating to resident care and treatment as a condition to continued employment by an adult care home. A course of instruction may be prepared and administered by any adult care home or by any other qualified person. A course of instruction prepared and administered by an adult care home -

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premises of the adult care home and which will administer instruction. The licensing agency shall prepare guidelines and administration of the course of instruction leading to an examination. The licensing agency shall approve or disapprove the course of instruction. Unlicensed employees who provide direct, in-person care to residents and who do not administer the approved course of instruction shall be reasonably supervised by licensed employees who provide direct, in-person care to residents and who do not administer the approved course of instruction.

shall fix, charge and collect fees to cover all or part of the cost of examination and instruction (c). The examination rules and regulations shall be approved by the licensing agency. The examination shall be administered in the state general fund. Unlicensed employees employed as attendants in an adult care home shall be supervised by the secretary of health and determines that the examination or examination of employees at least once a year. The examination shall be administered by a physician authorized by the board of health as needed. The examination shall require as a condition to the issuance of a license to an adult care home the applicant to be a licensed provider of medical services to a licensed adult care home.

Nothing in this subsection (f) shall be construed to abrogate or affect any agreements entered into prior to the effective date of this act between the adult care home and any person seeking admission to or resident of the adult care home.

(g) Except in emergencies as defined by rules and regulations of the licensing agency and except as otherwise authorized under federal law, no resident may be transferred from or discharged from an adult care home involuntarily unless the resident or legal guardian of the resident has been notified in writing at least 30 days in advance of a transfer or discharge of the resident.

(h) No resident who relies in good faith upon spiritual means or prayer for healing shall, if such resident objects thereto, be required to undergo medical care or treatment.

History: L. 1961, ch. 231, § 14; L. 1972, ch. 171, § 11; L. 1977, ch. 152, § 2; L. 1978, ch. 162, § 14; L. 1979, ch. 131, § 1; L. 1983, ch. 148, § 1; L. 1983, ch. 286, § 10; L. 1989, ch. 126, § 3; July 1.

Law Review and Bar Journal References:  
"Nursing Home Tort Litigation," Michael E. Callen, Vol. X, No. 1, J.K.T.L.A. 17 (1986).

**39-937. Compliance with other laws and regulations.** All pertinent laws of this state and lawfully adopted ordinances and rules and regulations shall be strictly complied with in the operation of any adult care home in this state.

History: L. 1961, ch. 231, § 15; L. 1972, ch. 171, § 12; July 1.

**39-938. Compliance with requirements and rules and regulations of licensing and other agencies; exceptions.** Adult care homes shall comply with all the lawfully established requirements and rules and regulations of the secretary of health and environment and the state fire marshal, and any other agency of government so far as pertinent and applicable to adult care homes, their buildings, operators, staffs, facilities, maintenance, operation, conduct, and the care and treatment of residents. The administrative rules and regulations of the state board of cosmetology and of the board of barber examiners shall not apply to adult care homes.

History: L. 1961, ch. 231, § 16; L. 1972, ch. 171, § 13; L. 1975, ch. 462, § 45; July 1.

**39-939. Unlawful acts.** It shall be unlawful in any adult care home to house, care

:(a) Any resident to stay in any room, area, or detached build-

neglect, or cruel treatment of  
 mission to resident status of any  
 is known to suffer from any  
 condition for which the home is  
 ed to provide care under the  
 f this act or the terms and con-  
 s license.  
 L. 1961, ch. 231, § 17; L. 1972,  
 § 1; July 1.

Forms for application, reports,  
 inspections; records open to  
 unlawful acts. (a) The secretary  
 and environment may prescribe  
 necessary forms for applications,  
 rds and inspections for adult  
 All prescribed records shall be  
 ection by the designated agents  
 ies administering this act.  
 ll be unlawful to:  
 false entries in such records;  
 any information required or  
 e report concerning any adult

ause to be filed such false or  
 eords or reports with the de-  
 ealth and environment or with  
 administering this act, knowing  
 eords or reports are false or  
 L. 1961, ch. 231, § 18; L. 1972,  
 L. 1975, ch. 462, § 46; L. 1981,  
 July 1.

Adult care homes; license and  
 certain organizations exempt.  
 this act shall be construed to  
 y licensed general hospital or  
 care facility operated by and in  
 with a licensed hospital, or to  
 e home operated by a bona fide  
 ligious order exclusively for the  
 bers of such order, and no rules,  
 or standards shall be made or  
 under this act for any adult care  
 lucted in accordance with the  
 j principles of the body known  
 ch of Christ Scientist, except as  
 ruption, sanitary and safe condi-  
 premises, cleanliness of opera-  
 physical equipment. Any orga-  
 empted by this provision may

apply for and receive a license, provided it  
 meets the requirements of this act.

History: L. 1961, ch. 231, § 19; L. 1972,  
 ch. 171, § 16; L. 1977, ch. 153, § 1; May 13.

**39-942. License in effect on effective  
 date of act continued in effect; exceptions.**  
 All licenses, issued under the provisions of  
 chapter 39, article 9, of the Kansas Statutes  
 Annotated, for adult care homes or homes  
 for the aged in force upon the taking effect  
 of this act shall continue in force until the  
 date of expiration unless sooner suspended  
 or revoked as provided in this act: *Provided*,  
 That all persons with such licenses in force  
 upon the effective date of this act shall be  
 permitted no less than four (4) months from  
 their effective date to comply with the rules,  
 regulations and standards promulgated  
 under the authority of this act wherein those  
 rules, regulations and standards differ in  
 any substantial respect from those in force  
 and effect immediately prior to the effective  
 date hereof under the provisions of chapter  
 39, article 9 of the Kansas Statutes Anno-  
 tated.

History: L. 1961, ch. 231, § 20; L. 1972,  
 ch. 171, § 17; July 1.

**39-943. Penalties.** Any person operat-  
 ing an adult care home in this state without  
 a license under this law shall be guilty of a  
 misdemeanor and upon conviction shall be  
 punished by a fine of not more than \$100, or  
 by imprisonment in the county jail for a  
 period of not more than six months, or by  
 both such fine and imprisonment. Any per-  
 son who shall violate any other provision of  
 this act or the requirements of any rules and  
 regulations promulgated hereunder shall be  
 guilty of a misdemeanor and shall upon  
 conviction thereof be punished by a fine of  
 not more than \$100, or by imprisonment in  
 the county jail for a period of not more than  
 six months, or by both such fine and im-  
 prisonment.

History: L. 1961, ch. 231, § 21; L. 1972,  
 ch. 171, § 18; L. 1982, ch. 189, § 4; Jan. 1,  
 1983.

**39-944. Injunctions and other process.**  
 Notwithstanding the existence or pursuit of  
 any other remedy, the secretary of health  
 and environment, as the licensing agency,  
 in the manner provided by the act for judi-  
 cial review and civil enforcement of agency  
 actions, may maintain an action in the name

the state of Kansas for injunction or other process against any person or agency to restrain or prevent the operation of an adult care home without a license under this act.

History: L. 1961, ch. 231, § 22; L. 1972, ch. 171, § 19; L. 1975, ch. 462, § 47; L. 1982, ch. 189, § 5; L. 1984, ch. 313, § 66; July 1, 1985.

**39-945.** Correction orders; issuance; contents. A correction order may be issued by the secretary of health and environment or the secretary's designee to a person licensed to operate an adult care home whenever the state fire marshal or the marshal's representative or a duly authorized representative of the secretary of health and environment inspects or investigates an adult care home and determines that the adult care home is not in compliance with the provisions of article 9 of chapter 39 of the Kansas Statutes Annotated or rules and regulations promulgated thereunder which individually or jointly affects significantly and adversely the health, safety, nutrition or sanitation of the adult care home residents. The correction order shall be served upon the licensee either personally or by certified mail, return receipt requested. The correction order, when in writing, shall state the specific deficiency, cite the specific statutory provision or rule and regulation alleged to have been violated and shall specify the time allowed for correction.

History: L. 1978, ch. 161, § 1; L. 1980, ch. 127, § 1; L. 1988, ch. 146, § 1; July 1.

**39-946.** Civil penalty; issuance; notice of assessment; factors in determining amount of civil penalty; enforcement. (a) If upon reinspection by the state fire marshal or the marshal's representative or a duly authorized representative of the secretary of health and environment, which reinspection shall be conducted within 14 days from the day the correction order is served upon the licensee, it is found that the licensee of the adult care home which was issued a correction order has not corrected the deficiency or deficiencies specified in the order, the secretary of health and environment may assess a civil penalty in an amount not to exceed \$500 per day per deficiency against the licensee of an adult care home for each day subsequent to the day following the time allowed for correction of the deficiency as specified in the correction order if the adult care home has not corrected the deficiency or deficiencies listed in the correc-

tion order, but the maximum assessment shall not exceed \$2,500. Prior to the assessment of a civil penalty, the case shall be reviewed by a person licensed to practice medicine and surgery. A written notice of assessment shall be served upon the licensee of an adult care home either personally or by certified mail, return receipt requested.

(b) Before the assessment of a civil penalty, the secretary shall consider the following factors in determining the amount of the civil penalty to be assessed: (1) The severity of the violation; (2) the good faith effort exercised by the adult care home to correct the violation; and (3) the history of compliance of the ownership of the adult care home with the rules and regulations. If the secretary of health and environment finds that some or all deficiencies cited in the correction order have also been cited against the adult care home as a result of any inspection or investigation which occurred within 18 months prior to the inspection or investigation which resulted in such correction order, the secretary of health and environment may double the civil penalty assessed against the licensee of the adult care home, the maximum not to exceed \$5,000.

(c) All civil penalties assessed shall be due and payable within 10 days after written notice of assessment is served on the licensee, unless a longer period of time is granted by the secretary. If a civil penalty is not paid within the applicable time period, the secretary of health and environment may file a certified copy of the notice of assessment with the clerk of the district court in the county where the adult care home is located. The notice of assessment shall be enforced in the same manner as a judgment of the district court.

History: L. 1978, ch. 161, § 2; L. 1980, ch. 127, § 2; L. 1988, ch. 146, § 2; July 1.

**39-947.** Appeals to secretary; hearing; disposition of civil penalties. Any licensee against whom a civil penalty has been assessed under K.S.A. 39-946, and amendments thereto, may appeal such assessment within 10 days after receiving a written notice of assessment by filing with the secretary of health and environment written notice of appeal specifying why such civil penalty should not be assessed. Such appeal shall not operate to stay the payment of the civil penalty. Upon receipt of the notice of appeal, the secretary of health and environment shall conduct a hearing in accordance with

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with the provisions of the Kansas administrative procedure act. If the secretary sustains the appeal, any civil penalties collected shall be refunded forthwith to the appellant licensee with interest at the rate established by K.S.A. 16-204, and amendments thereto, from the date of payment of the civil penalties to the secretary. If the secretary denies the appeal and no appeal from the secretary is taken to the district court in accordance with the provisions of the act for judicial review and civil enforcement of agency actions, the secretary shall dispose of any civil penalties collected as provided in K.S.A. 39-949, and amendments thereto.

History: L. 1978, ch. 161, § 3; L. 1980, ch. 127, § 3; L. 1984, ch. 313, § 67; July 1, 1985.

**39-948.** Appeals to district court; disposition of civil penalties. (a) A licensee may appeal to the district court from a decision of the secretary under K.S.A. 39-947, and amendments thereto. The appeal shall be tried in accordance with the provisions of the act for judicial review and civil enforcement of agency actions.

(b) An appeal to the district court or to an appellate court shall not stay the payment of the civil penalty. If the court sustains the appeal, the secretary of health and environment shall refund forthwith the payment of any civil penalties to the licensee with interest at the rate established by K.S.A. 16-204, and amendments thereto, from the date of payment of the civil penalties to the secretary. If the court denies the appeal, the secretary of health and environment shall dispose of any civil penalties collected as provided in K.S.A. 39-949, and amendments thereto.

History: L. 1978, ch. 161, § 4; L. 1980, ch. 127, § 4; L. 1984, ch. 313, § 68; July 1, 1985.

**39-949.** Disposition of moneys. All civil penalties collected pursuant to the provisions of this act shall be deposited in the state general fund.

History: L. 1978, ch. 161, § 5; July 1.

**39-950.** Rules and regulations. The secretary of health and environment may adopt rules and regulations necessary to carry out the provisions of this act.

History: L. 1978, ch. 161, § 6; July 1.

**39-951.** Authority granted under act additional and not limiting. The authority granted to the secretary of health and environment under this act is in addition to other statutory authority the secretary has to require the licensing and operation of adult care homes and is not to be construed to limit any of the powers and duties of the secretary under article 9 of chapter 39 of the Kansas Statutes Annotated.

History: L. 1978, ch. 161, § 7; July 1.

**39-952.** Correction order not issued, when. The secretary of health and environment or the secretary's designee shall not issue a correction order to a person licensed to operate an adult care home because of a violation of a provision of article 9 of chapter 39 of the Kansas Statutes Annotated or a rule and regulation adopted thereunder which was caused by any person licensed by the state board of healing arts if such person licensed by the state board of healing arts is not an owner, operator or employee of the adult care home and if the person licensed to operate the adult care home shows that he or she has exercised reasonable diligence in notifying such person licensed by the state board of healing arts of his or her duty to the residents of the adult care home.

History: L. 1978, ch. 161, § 8; July 1.

**39-953.** Citation of act. K.S.A. 39-923 to 39-944, inclusive, and acts amendatory thereof or supplemental thereto, and K.S.A. 39-931a and 39-945 to 39-952, inclusive, and acts amendatory thereof or supplemental thereto, shall be known and may be cited as the adult care home licensure act.

History: L. 1978, ch. 161, § 10; July 1.

**39-953a.** Order prohibiting new admissions to adult care home; when issued; proceedings; remedy not limiting. (a) At any time the secretary of health and environment initiates any action concerning an adult care home in which it is alleged that there has been a substantial failure to comply with the requirements, standards or rules and regulations established under the adult care home licensure act, that conditions exist in the adult care home which are life threatening or endangering to the residents of the adult care home, that the adult care home is insolvent, or that the adult care home has deficiencies which significantly

ely affect the health, safety, nutri-  
 itation of the adult care home re-  
 e secretary may issue an order,  
 o the emergency proceedings pro-  
 nder the Kansas administrative pro-  
 , prohibiting any new admissions  
 ult care home until further deter-  
 by' the secretary. This remedy  
 the secretary is in addition to any  
 tory authority the secretary has re-  
 e licensure and operation of adult  
 s and is not be construed to limit  
 powers and duties of the secretary  
 adult care home licensure act.  
 section shall be part of and sup-  
 o the adult care home licensure act.  
 L. 1988, ch. 146, § 3; July 1.

Annual report of violations re-  
 ssuance of correction orders and  
 ss. (a) The secretary shall issue an-  
 ch adult care home a report sum-  
 category of licensure, violation and  
 occurrence those violations which  
 d in the issuance of correction or-  
 il penalties within the preceding  
 h period.  
 tion shall be part of and sup-  
 e adult care home licensure act.  
 1988, ch. 146, § 4; July 1.

**RECEIVERSHIP**

Application for receiver; order  
 qualifications of persons desig-  
 method of selection, rules and  
 (a) The secretary of health and  
 (b) the owner of an adult care  
 e person licensed to operate an  
 home may file an application  
 istrict court for an order appoint-  
 etary of health and environment  
 nee of the secretary as receiver  
 a adult care home whenever: (1)  
 exist in the adult care home that  
 atening or endangering to the  
 the adult care home; (2) the  
 ome is insolvent; or (3) the sec-  
 lth and environment has issued  
 oking the license of the adult  
  
 ecretary of health and environ-  
 dopt rules and regulations set-  
 he necessary qualifications of

persons to be designated receivers and a  
 method for selecting designees.  
 History: L. 1978, ch. 162, § 1; L. 1985,  
 ch. 151, § 1; July 1.

**39-955.** Filing application for receiver-  
 ship; contents. The application for receiver-  
 ship shall be filed in the district court in  
 the county where the adult care home is  
 located. The application shall be verified  
 and set forth the specific reasons therefor.  
 History: L. 1978, ch. 162, § 2; July 1.

**39-956.** Service of copies of application  
 for receivership; posting in adult care home.  
 The applicant shall serve those persons set  
 forth in K.S.A. 39-954 with copies of the  
 application. Service of process shall be as  
 provided for under the code of civil proce-  
 dure. The applicant shall also send five (5)  
 copies of the application for receivership to  
 the adult care home. The adult care home  
 shall post the copies of the application in  
 conspicuous places within the adult care  
 home.  
 History: L. 1978, ch. 162, § 3; July 1.

**39-957.** Answer to application for re-  
 ceivership. A party shall file an answer to  
 the application within five (5) days after the  
 service of the application upon such person.  
 History: L. 1978, ch. 162, § 4; July 1.

**39-958.** Priority of application for re-  
 ceivership in district court; evidence; ap-  
 pointment of receiver; certain statutes in-  
 applicable to license granted receiver;  
 length of license. The application for re-  
 ceivership shall be given priority by the  
 district court and shall be heard no later  
 than the seventh (7th) day following the  
 filing of the application. A continuance of  
 no more than ten (10) days may be granted  
 by the district court for good cause. The  
 district court shall give all parties who have  
 filed an answer the opportunity to present  
 evidence pertaining to the application. If  
 the district court finds that the facts warrant  
 the granting of the application, the court  
 shall appoint the secretary of health and  
 environment or the designee of the secre-  
 tary as receiver to operate the home.

Upon the appointment of a receiver under  
 this section, the receiver shall be granted a  
 license by the licensing agency to operate

an adult care home as provided under the provisions of article 9 of chapter 39 of the Kansas Statutes Annotated, and acts amending the provisions thereof or acts supplemental thereto. The provisions of article 9 of chapter 39 of the Kansas Statutes Annotated, and acts amending the provisions thereof and acts supplemental thereto, relating to inspection prior to granting a license to operate an adult care home and relating to payment of license fees shall not apply to a license granted to a receiver under this section, and such license shall remain in effect during the existence of the receivership and shall expire on the termination of the receivership. The receiver shall make application for the license on forms provided for this purpose by the licensing agency.

History: L. 1978, ch. 162, § 5; July 1.

**39-959.** Powers and duties of receiver. A receiver appointed in accordance with the provisions of this act shall have the following powers and duties:

- (a) Conduct the day to day business operations of the adult care home;
- (b) reimburse the owner or licensee, as appropriate, a fair monthly rental for the adult care home, taking into account all relevant factors, including the condition of such adult care home and set-offs arising from improvements made by the receiver;
- (c) give fair compensation to the owner or licensee, as appropriate, for all property taken or used during the course of the receivership if such person has not previously received compensation for the property being taken or used;
- (d) correct or eliminate any deficiency in the adult care home that concerns the health, safety, nutrition, or sanitation of the residents of the adult care home and is life threatening or endangering;
- (e) enter into contracts as necessary to carry out his or her duties as receiver and incur expenses for individual items of repairs, improvements or supplies without the procurement of competitive bids, if otherwise required by law, where the total amount of such individual item does not exceed five hundred dollars (\$500);
- (f) collect incoming payments from all sources and apply them to the costs incurred in the performance of his or her functions as receiver including the compensation of the receiver, if any;

- (g) honor all existing leases, mortgages, chattel mortgages and security interests;
- (h) operate the adult care home so as to provide safe and adequate health care for the residents of the adult care home;
- (i) provide for the orderly transfer of all residents in the adult care home to other adult care homes or make other provisions for their continued safety and health care, as necessary;
- (j) other powers and duties as authorized or imposed by the district court.

History: L. 1978, ch. 162, § 6; July 1.

**39-960.** Expenditures from moneys appropriated for purposes of act; when authorized; repayment. The secretary of social and rehabilitation services, upon request of a receiver, may authorize expenditures from moneys appropriated for purposes set forth in this act if incoming payments from the operation of the adult care home are less than the cost incurred by the receiver in the performance of the receiver's functions as receiver or for purposes of initial operating expenses of the receivership. Any payments made by the secretary of social and rehabilitation services pursuant to this section shall be owed by the owner or licensee and repaid to the secretary of social and rehabilitation services when the receivership is terminated pursuant to K.S.A. 39-963 and amendments thereto and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.

History: L. 1978, ch. 162, § 7; L. 1984, ch. 158, § 1; July 1.

**39-961.** Department of health and environment to assist receiver; expenses of department; repayment. The personnel and facilities of the department of health and environment shall be available to the receiver for the purposes of carrying out the receiver's duties as receiver as authorized by the secretary of health and environment.

The department of health and environment shall itemize and keep a ledger showing costs of personnel and other expenses establishing the receivership and assisting the receiver and such amount shall be owed by the owner or licensee to the department of health and environment. Such department shall submit a bill for such expenses to the receiver for inclusion in the receiver's final accounting. Any amount so billed and until repaid shall constitute a lien against all

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non-exempt personal and real property of the owner or licensee.

History: L. 1978, ch. 162, § 8; L. 1984, ch. 158, § 2; July 1.

**39-962.** Supervision of district court; final accounting; removal. The receiver shall be subject to the supervision of the district court. The receiver shall file a final accounting with the district court upon the termination of the receivership. The receiver shall be subject to removal by the district court for good cause.

History: L. 1978, ch. 162, § 9; July 1.

**39-963.** Termination of receivership; circumstances; accounting and disposition of money; court orders for recovery of certain expenses and costs. (a) The court shall terminate the receivership only under any of the following circumstances:

- (1) Twenty-four months after the date on which the receivership was ordered;
- (2) a new license, other than the license granted to the receiver under K.S.A. 39-958 and amendments thereto, has been granted to operate the adult care home; or
- (3) at such time as all of the residents in the adult care home have been provided alternative modes of health care, either in another adult care home or otherwise.

(b) At the time of termination of the receivership, the receiver shall render a full and complete accounting to the district court and shall make disposition of surplus money at the direction of the district court.

The court may make such additional orders as are appropriate to recover the expenses and costs to the department of health and environment and the secretary of social and rehabilitation services incurred pursuant to K.S.A. 39-960 or 39-961 and amendments thereto.

History: L. 1978, ch. 162, § 10; L. 1984, ch. 158, § 3; July 1.

**39-964.** Procedures for and review and enforcement of administrative actions. (a) The provisions of the Kansas administrative procedure act and the act for judicial review and civil enforcement of agency actions shall govern all administrative proceedings conducted pursuant to K.S.A. 39-945 through 39-963, and amendments thereto, except to the extent that the provisions of the above-named acts would conflict with

the procedures set forth in the above-mentioned statutes.

(b) This section shall be a part of and supplemental to article 9 of chapter 39 of the Kansas Statutes Annotated.

History: L. 1984, ch. 313, § 69; July 1, 1985.

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30-10-215 (1)

30-10-215. ICF-MR rates; effective dates. (a) Effective date of per diem rates for existing facilities. The effective date of a new rate that is based on information and data in the ICF/MR cost report shall be the first day of the third calendar month following the month the complete cost report is received by the agency.

(b) Effective date of the per diem rate for a new provider. The effective date of the per diem rate for a new provider, as set forth in subsection (c) of K.A.R. 30-10-214, shall be the date of certification by the department of health and environment pursuant to 42 CFR section 442.13, effective October 3, 1988, which is adopted by reference. The interim rate determined from an approved projected cost report filed by the provider shall be established with the fiscal agent by the first day of the third month after the receipt of a complete and workable cost report. The effective date of the final rate, determined after audit of the historical cost report filed for the projection period, shall be the date of certification by the department of health and environment.

(c) Effective date of the per diem rate for a new provider resulting from a change in provider.

(1) The effective date of the per diem rate for a change in provider, as set forth in K.A.R. 30-10-215, shall be the date of certification by the department of health and environment. The effective date of the final rate, determined after audit of the historical cost report filed for the projection period, shall be the date of certification by the department of health and environment.

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30-10-215 (2)

(2) The effective date of the projected and final rate for a new provider, as set forth in K.A.R. 30-10-214, shall be the later of the date of the receipt of the ICF-MR financial and statistical report or the date the new construction is certified.

(d) The effective date of the per diem rates for providers with more than one facility filing an historic cost report, in accordance with K.A.R. 30-10-213, shall be the first day of the third calendar month after all cost reports due from that provider have been received.

(e) The effective date for a provider filing an historic cost report covering a projection status period shall be the first day of the month following the report year-end. This is the date that historic and estimated inflation factors are applied in determining prospective rates. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

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§ 442.13

42 CFR CH. IV (10-1-85 Edition)

(45 FR 22736, Apr. 4, 1980)

§ 442.13 Effective date of agreement.

(a) *Basic requirements.* If the Medicaid agency enters into a provider agreement, the effective date must be in accordance with this section.

(b) *All Federal requirements are met on the date of the survey.* The agreement must be effective on the date the onsite survey is completed (or on the day following the expiration of a current agreement) if, on the date of the survey, the provider meets:

- (1) All Federal health and safety standards; and
- (2) Any other requirements imposed by the Medicaid agency.

(c) *All Federal requirements are not met on the date of the survey.* If the provider fails to meet any of the requirements specified in paragraph (b) of this section, the agreement must be effective on the earlier of the following dates:

- (1) The date on which the provider meets all requirements.
- (2) The date on which the provider submits a correction plan acceptable to the State survey agency or an approvable waiver request, or both.

(45 FR 22736, Apr. 4, 1980)

Kansas Medicaid Plan

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Substitute per letter dated 06/16/98<sup>n</sup>

ICF-MR Choosing to Cease Operation Requesting Assistance Through an Approved ICF-MR Closure Plan.

A. Parameters of Closure Plan

The closure plan will be written and cover a specified time period, agreed upon by the affected ICF-MR and Social and Rehabilitation Services, Commission of Mental Health and Developmental Disabilities (SRS/MH&DD), not to exceed twelve continuous months. The affected ICF-MR will have the characteristics of a provider who has received approval from the Department of Social and Rehabilitation Services for closure. The monthly attrition rate will be the total number of individuals residing in the facility, divided by the number of months specified for the facility closure. The rate of placement will be the same for individuals who are Medicaid eligible and individuals who are Non-Medicaid eligible. Each individual will be placed out of the ICF-MR, according to the life style preferences documented in their person-centered plan, and in compliance with the Developmental Disability Reform Act, K.S.A. 39-1801 et seq.(attached). The individual/guardian will have the choice of where to live and who will provide services. The Community Developmental Disabilities Organization (CDDO) of the chosen area will be responsible for arranging needed services.

B. Budget Projection

The affected ICF-MR will submit a projected budget to SRS/MH&DD for approval, two months before the start of the agreed upon closure period. The projected budget will be based on the fixed costs of the operation reflected in the most recent historical cost report submitted to SRS/MH&DD, and the variable costs related to the expected decrease in volume of service due to attrition. Fixed costs are those costs incurred to provide a service regardless of whether one delivers one unit of service or one thousand, i.e. rental/lease agreements and occupancy costs. Variable costs are those costs that can be presumed to decrease in roughly direct relationship to the amount of service delivered, i.e. supplies, some categories of staff salaries. The affected ICF-MR will be exempt from the cost center limits and placed on projected status for a maximum twelve month closure period. Under no circumstances will SRS/MH&DD pay more for the ICF-MR in total than it would have paid if it remained in operation. The ICF-MR will submit quarterly cost reports to SRS/MH&DD in order to monitor fiscal status related to projected budget. The cost report will be an abbreviated form of the annual historical cost report and will document the expenditures of the major cost centers; Administrative, Plant Operation, Habilitation, and Room and Board.

TN# MS 98-04 Approval Date JUN 26 1998 Effective Date 1-01-98 Supersedes TN N/A

Kansas Medicaid Plan

Substitute per letter dated 06/16/98 "

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C. Methodology

The ICF-MR will calculate a projected per diem rate by dividing the projected budget by the projected bed days for the closure period. The closure plan will allow for a settlement to the affected ICF-MR if the final cost report indicates that reasonable actual costs varied from the amount paid according to the method of rate setting described above.

D. Repayment

The affected ICF-MR will repay SRS/MH&DD for all costs incurred in excess of allowable cost limits established by SRS/MH&DD, in the event of failure to close within the agreed upon time frame. The repayments may be amortized over a period of time not to exceed twelve calendar months.

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Substitute for Letter dated 06/16/98 "

**Public process for proposed Methodology for closure of ICFs/MR.**

The state has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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30-10-216. ICF-MR payment of claims. (a) Payment to participating provider. Each participating provider shall be paid, at least monthly, a per diem rate for ICF-MR services, excluding client liability, rendered to eligible clients provided that:

(1) The agency is billed on the turn-around document or electronic claims submission furnished by the contractor serving as the fiscal agent for the medicaid/medikan program;

(2) the turn-around document or electronic claims submission is verified by the administrator of the facility or a designated key staff member; and

(3) the claim is filed no more than six months after the time the services were rendered pursuant to K.S.A. 39-708a, and any amendments thereto.

(b) Client's liability. The client's liability for services shall be the amount determined by the local agency office in which a medicaid/medikan client or the client's agent applies for care. The client's liability begins on the first day of each month and shall be applied in full prior to any liability incurred by the medicaid/medikan program. The unexpended portion of the client's liability payment shall be refunded to the client or client's agent if the client dies or otherwise permanently leaves the facility.

(c) The payment of claims may be suspended if there has been an identified overpayment and the provider is financially insolvent. (Authorized by and implementing K.S.A. 39-708c, as amended by L.

ATTORNEY GENERAL

DEPT. OF ADMINISTRATION

NOV 16 1990

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1990, Chapter 152; effective, T- 30-12-28-90, Dec. 28, 1990 ;  
effective P- March 4, 1991 .)

ATTORNEY GENERAL

DEPT. OF ADMINISTRATION

NOV 16 1990

TN# MS-91-14 Approval Date JUN 12 1991 Effective Date JAN - 1 1991 Superseded MS-90-46

30-10-217 (1)

30-10-217. ICF-MR reserve days. (a) Payment shall be available for days for which it is necessary to reserve a bed in an intermediate care facility for the mentally retarded when the client is absent for:

- (1) Admission to a hospital for acute conditions;
- (2) a temporary absence for therapeutically indicated home visits with relatives or friends; or
- (3) a temporary absence to participate in state-approved therapeutic or rehabilitative programs.

(b) Payment shall be available only for the days during which there is a likelihood that the reserved bed would otherwise be required for occupancy by some other client.

(c) The provider shall be required to notify the local agency office prior to routine absence from the facility by clients in the Kansas medicaid/medikan program. In case of routine admission to a hospital, notification must be submitted to the local agency office no later than five working days following admission.

(d) No payment for medical reserve days shall be made until authorization has been given by the local agency office in writing to the provider. A copy of the authorization shall be attached to the claim submitted for payment.

(e) The following conditions shall be met when a bed is reserved in an ICF/MR because of hospitalization for an acute medical condition:

30-10-217 (2)

(1) The local agency office has approved the client reserve days for hospitalization of an acute condition for each period of hospitalization up to 10 days.

(2) When ICF/MR clients are transferred to one of the state mental retardation facilities, they are eligible for 21 hospital reserve days.

(3) The client shall intend to return to the same facility after the hospitalization and the facility accepts the individual for service.

(4) The hospital shall provide a discharge plan for the client which includes returning to the facility requesting the reserve days.

(5) An ICF/MR which has less than 90% occupancy may not be approved for hospitalization reserve days.

(f) The client's plan of care shall provide for the non-hospital related absence. Payment for non-hospital related reserve days for eligible clients residing in intermediate care facilities for the mentally retarded shall not exceed 21 days per calendar year, including travel. If additional days are required to alleviate a severe hardship or facilitate normalization, the ICF-MR provider shall send the request for additional days and supporting documentation to the agency for approval or disapproval.

(g) This regulation shall not prohibit any client from leaving a facility if the client so desires.

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(h) Payments made for unauthorized reserve days shall be reclaimed by the agency. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

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30-10-218 (1)

30-10-218. ICF-MR non-reimbursable costs. (a) Costs not related to client care, as set forth in K.A.R. 30-10-200, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

- (1) Fees paid to non-working directors and the salaries of non-working officers;
- (2) bad debts;
- (3) donations and contributions;
- (4) fund-raising expenses;
- (5) taxes, including:
  - (A) Federal income and excess profit taxes, including any interest or penalties paid thereon;
  - (B) state or local income and excess profits taxes;
  - (C) taxes from which exemptions are available to the provider;
  - (D) taxes on property which is not used in providing covered services;
  - (E) taxes levied against any client and collected and remitted by the provider;
  - (F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and
  - (G) interest or penalties paid on federal and state payroll taxes;
- (6) insurance premiums on lives of officers and owners;
- (7) the imputed value of services rendered by non-paid workers and volunteers;
- (8) utilization review;
- (9) costs of social, fraternal, and other organizations which concern themselves with activities unrelated to their members' professional or business activities;

TN#MS-91-45 Approval Date 7-18-95 Effective Date 10-1-91 Supersedes TN#MS-91-14

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- (10) oxygen;
  - (11) vending machine and related supplies;
  - (12) board of director costs;
  - (13) client personal purchases;
  - (14) barber and beauty shop expenses;
  - (15) advertising for client utilization;
  - (16) public relations expenses;
  - (17) penalties, fines, and late charges;
  - (18) items or services provided only to non-medicaid/medikan clients and reimbursed from third party payors;
  - (19) automobiles and related accessories in excess of \$25,000.00. Buses and vans for client transportation shall be reviewed for reasonableness and may exceed \$25,000.00 in costs;
  - (20) airplanes and associated expenses;
  - (21) costs of legal fees incurred in actions brought against the agency;
  - (22) aggregate costs incurred in excess of historical or projected costs plus allowed inflation, without prior authorization of the agency; and
  - (23) costs incurred through providing service to a bed made available through involuntary discharge of a client as determined by the Kansas department of health and environment without prior authorization of the agency.
- (b) The following contract cost under the day habilitation program shall not be allowed:
- (1) Client salaries and FICA match;
  - (2) all material costs, including sub-contracts;
  - (3) all costs related to securing contracts; and
  - (4) 50% of the cost of the following items:

Substitute per letter dated 11/13/96 W

REPLACEMENT PAGE  
NOVEMBER 13, 1996

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- (A) cost of equipment lease;
  - (B) maintenance of equipment;
  - (C) purchase of small tools under \$100.00; and
  - (D) depreciation of production equipment.
- (c) ICFs/MR shall not be reimbursed for services provided to individuals admitted on or after the effective date of this regulation unless:
- (1) the community developmental disability organization (CDDO) assigned by the agency first determines such persons meet eligibility requirements established by the agency and the ICF/MR placement is consistent with the preferred lifestyle of the person as specified by the person or the person's guardian, if one has been appointed; or,
  - (2) the admission has been otherwise approved by the agency Commissioner of Mental Health and Developmental Disabilities.

The effective date of this regulation shall be April 17, 1996.  
(Authorized by and implementing K.S.A. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4; amended Oct. 1, 1991; amended April 17, 1996.)

TN#MS-96-06 Approval Date DEC 20 1996 Effective 04-17-96 Supersedes #MS-91-45

30-10-219 .(1)

30-10-219. ICF-MR costs allowed with limitations. (a) The following expenses or costs shall be allowed with limitations:

(1) Loan acquisition fees and standby fees shall be amortized over the life of the related loan if the loan is related to client care.

(2) Only the taxes specified below shall be allowed as amortized costs.

(A) Taxes in connection with financing, re-financing, or re-funding operations; and

(B) special assessments on land for capital improvements over the estimated useful life of those improvements.

(3) Purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior year expense payments shall also be deducted from the related expenses.

(4) Any start-up cost of a provider shall be recognized if it is:

(A) Incurred prior to the opening of the facility and related to developing the ability to care for clients;

(B) amortized over a period of not less than 60 months;

(C) consistent with the facility's federal income tax return, and internal and external financial reports with the exception of

(B) above; and

(D) identified in the cost report as a start-up cost which may include:

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(i) Administrative salaries limited to three months prior to licensing;

(ii) employee salaries limited to one month prior to licensing;

(iii) utilities;

(iv) taxes;

(v) insurance;

(vi) mortgage interest;

(vii) employee training costs; and

(viii) any other allowable costs incidental to the start-up of the facility as prior approved by the agency.

(5) Any cost which can properly be identified as organization expenses or can be capitalized as construction expenses shall be appropriately classified and excluded from start-up cost.

(6) Organization and other corporate costs, as defined in K.A.R. 30-10-200, of a provider that is newly organized shall be amortized over a period of not less than 60 months beginning with the date of organization.

(7) Membership dues and costs incurred as a result of membership in professional, technical, or business-related organizations shall be allowable. However, similar expenses set forth in paragraph (a)(9) of K.A.R. 30-10-218 shall not be allowable.

(8) (A) Costs associated with services, facilities, and supplies furnished to the ICF-MR by related parties, as defined in K.A.R. 30-10-200, shall be included in the allowable cost of the facility at the actual cost to the related party, except that the allowable

30-10-219 (3)

cost to the ICF-MR provider shall not exceed the lower of the actual cost or the market price.

(B) When a provider chooses to pay an amount in excess of the market price for supplies or services, the agency shall use the market price to determine the allowable cost under the medicaid/medikan program in the absence of a clear justification for the premium.

(9) The net cost of approved staff educational activities shall be an allowable cost. The net cost of "orientation" and "on-the-job training" shall not be within the scope of approved educational activities, but shall be recognized as normal operating costs.

(10) Client-related transportation costs shall include only reasonable costs that are directly related to client care and substantiated by detailed, contemporaneous expense and mileage records. Transportation costs only remotely related to client care shall not be allowable. Estimates shall not be acceptable.

(11) Lease payments. Lease payments shall be reported in accordance with the financial account statements of the Financial Accounting Standards Board.

(12) The actual cost of airplanes and associated expenses are not allowed. However, the provider may charge the equivalent distance of automobile mileage at the IRS allowable rate. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

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30-10-220

30-10-220. ICF-MR revenues. A statement of revenue shall be required as part of the cost report forms. (a) Revenue shall be reported in accordance with general accounting rules as recorded in the accounting records of the facility and as required in the detailed revenue schedule in the uniform cost report.

(b) The non-reimbursable cost of goods and services provided to clients shall be deducted from the related expense item. The net expense shall not be less than zero.

(c) Revenue received for a service that is not related to client care shall be used to offset the cost of providing that service provided that excess revenue received for such service shall be distributed to the entire agency based on generally accepted accounting principles. The cost report line item which includes the non-client related costs shall not be less than zero. Miscellaneous revenue with insufficient explanation in the cost report shall be offset.

(d) Expense recoveries credited to expense accounts shall not be reclassified as revenue to increase the costs reported in order to qualify for a higher rate.

(e) Each ICF-MR provider with a day habilitation program shall not be required to deduct the income earned from the costs incurred on contracts. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

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30-10-221 (1)

30-10-221. ICF-MR compensation of owners, spouses, related parties and administrators. (a) Non-working owners and related parties. Remunerations paid to non-working owners or other related parties, as defined in K.A.R. 30-10-200, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-client related expense section of the cost report.

(b) Services related to client care.

(1) If owners with 5% or more ownership interest, spouses, or related parties actually perform a necessary function directly contributing to client care, a reasonable amount shall be allowed for such client care activity. The reasonable amount allowed shall be the lesser of:

(A) The reasonable cost that would have been incurred to pay a non-owner employee to perform the client-related services actually performed by owners or other related parties, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed until the subsequent cost report is filed; or

(B) the amount of cash and other assets actually withdrawn by the owner, spouse, or related parties.

(2) The client-related functions shall be limited to those functions common to the industry and for which cost data is available which are normally performed by non-owner employees. The job titles for administrative and supervisory duties performed by an owner, spouse, or related party shall be limited to the work activities included in the schedule of the owner, spouse, or related party salary limitations.

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(3) The salary limit shall also be pro-rated in accordance with subsection (c) of this regulation. In no case shall the limitation exceed the highest salary limit on the civil-service-based chart.

(4) The owner, spouse, or related party shall be professionally qualified for those functions performed which require licensure or certification.

(5) Cash and other assets actually withdrawn shall include only those amounts or items actually paid or transferred during the cost reporting period in which the services were rendered and reported to the internal revenue service.

(6) Any liabilities of the provider shall be paid in cash within 75 days after the end of the accounting period.

(c) Allocation of owner, spouse, or related party total work time for client-related functions. When any owner, spouse, or related party performs a client-related function for less than a full-time-equivalent work week, the compensation limit shall be pro-rated. The time spent on each function within a facility or within all facilities in which they have an ownership or management interest, shall be pro-rated separately by function, but shall not exceed 100% of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

(d) Reporting owner, spouse, or related party compensation on cost report. Owner, spouse, or related party compensation shall be reported on the owner compensation line in the appropriate cost center for the work activity involved. Any compensation paid to employees who have an ownership interest of 5% or more, including employees at the central office of a chain organization, shall be considered to be owner compensation. Providers with professionally qualified owner, spouse, or related party employees performing duties other than those for

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which they are professionally qualified shall report the cost for such duties in the administrative cost center.

(e) Owner-administrator compensation limitation.

(1) Reasonable limits shall be determined by the agency for owner-administrator compensation based upon the current civil service salary schedule.

(2) This limitation shall apply to the salaries of each administrator and co-administrator of that facility and to owner compensation reported in the administrative cost center of the cost report. This limitation shall apply to the salary of the administrator and co-administrator, regardless of whether they have any ownership interest in the business entity.

(3) Each salary in excess of the owner, spouse, or related party limitations determined in accordance with subsections (b) and (c) of this regulation shall be transferred to the owner compensation line in the administrative cost center and shall be subject to the owner-administrator compensation limitation.

(f) Management consultant fees. Fees for consulting services provided by the following professionally qualified people shall be considered owner's compensation subject to the owner-administrator compensation limit and shall be reported on the owner compensation line in the administrative cost center if the actual cost of the service is not submitted with the ICF-MR financial and statistical report:

- (1) Related parties as defined in K.A.R. 30-10-200;
- (2) current owners of the provider agreement and operators of the facility;
- (3) current owners of the facility in a lessee-lessor relationship;
- (4) management consulting firms owned and operated by former business associates of the current owners in this and other states;

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(5) owners who sell and enter into management contracts with the new owner to operate the facility; and

(6) accountants, lawyers and other professional people who have common ownership interests in other facilities, in this or other states, with the owners of the facility from which the consulting fee is received.

(g) Costs not related to client care. An allowance shall not be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, administrative or managerial activities performed by owners or other related parties that are not directly related to client care. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

30-10-222. ICF-MR ownership reimbursement fee. (a) The agency shall determine an allowable cost for ownership.

(b) (1) The ownership allowance shall include an appropriate component for:

- (A) Rent or lease expense;
- (B) interest expense on real estate mortgage;
- (C) amortization of leasehold improvements; and
- (D) depreciation on buildings and equipment.

(2) The ownership allowance shall be subject to a facility maximum.

(c) (1) The depreciation component of the ownership allowance shall be:

(A) Identifiable and recorded in the provider's accounting records;

(B) based on the historical cost of the asset as established in this regulation; and

(C) pro-rated over the estimated useful life of the asset using the straight-line method.

(2) (A) Appropriate recording of depreciation shall include identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, the assets' estimated useful life, and the assets' accumulated depreciation.

(B) Gains and losses on the sale of depreciable personal property shall be reflected on the cost report at the time of such sale. Trading of depreciable property shall be recorded in

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accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets are not recognized in the year of trade but are used to adjust the basis of the newly acquired property.

(3) (A) Gains from the sale of depreciable assets while the provider participates in the medicaid/medikan program, or within one year after the provider terminates participation in the program, shall be used to reduce the allowable costs for each cost reporting period prior to the sale, subject to limitation. The total sale price shall be allocated to the individual assets sold on the basis of an appraisal by a qualified appraiser or on the ratio of the seller's cost basis of each asset to the total cost basis of the assets sold.

(B) The gain on the sale shall be defined as the excess of the sale price over the cost basis of the asset. The cost basis for personal property assets shall be the book value. The cost basis for real property assets sold or disposed of before July 18, 1984, shall be the lesser of the book value adjusted for inflation by a price index selected by the agency or an appraisal by an American institute of real estate appraiser or an appraiser approved by the agency. The cost basis for real property assets sold or disposed of after July 17, 1984 shall be the book value.

(C) The gain on the sale shall be multiplied by the ratio of depreciation charged while participating in the medicaid/medikan

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program to the total depreciation charged since the date of purchase or acquisition. The resulting product shall be used to reduce allowable cost.

(4) For depreciation purposes, the cost basis for a facility acquired after July 17, 1984 shall be the lesser of the acquisition cost to the holder of record on that date or the purchase price of the asset. The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, including legal fees, accounting fees, travel costs and the cost of feasibility studies. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T- 30-12-28-90, Dec. 28, 1990 ; effective P- March 4, 1991 .)

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TN# MS-91-14 Approval Date JUN 12 1991 Effective Date JAN - 1 1991 Superseded MS-90-46

30-10-223. ICF-MR interest expense. (a) Only necessary and proper interest on working capital indebtedness shall be an allowable cost.

(b) The interest expense shall be incurred on indebtedness established with:

(1) Lenders or lending organizations not related to the borrower; or

(2) partners, stockholders, home office organizations, or related parties, if the following conditions are met:

(A) The terms and conditions of payment of the loans shall resemble terms and conditions of an arms-length transaction by a prudent borrower with a recognized, local lending institution with the capability of entering into a transaction of the required magnitude.

(B) The provider shall demonstrate, to the satisfaction of the agency, a primary business purpose for the loan other than increasing the per diem rate.

(C) The transaction shall be recognized and reported by all parties for federal income tax purposes.

(c) When the general fund of an ICF-MR "borrows" from a donor-restricted fund, this interest expense shall be an allowable cost if it is considered by the agency to be reasonable. In addition, if an ICF-MR operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

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(d) The interest expense shall be reduced by the investment income from restricted or unrestricted idle funds or funded reserve accounts, except when that income is from gifts and grants, whether restricted or unrestricted, which are held in a separate account and not commingled with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

(e) Interest earned on restricted or unrestricted reserve accounts of industrial revenue bonds or sinking fund accounts shall be offset against interest expense and limited to the interest expense on the related debt.

(f) Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost or the cost basis recognized for program purposes shall not be considered to be reasonable related to client care. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-12-28-90, Dec. 28, 1990; effective P- March 4, 1991.)

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30-10-224. ICF-MR central office costs. (a) Allocation of central office costs shall be reasonable, conform to general accounting rules, and allowed only to the extent that the central office is providing a service normally available in the ICF-MR. Central office costs shall not be recognized or allowed to the extent they are unreasonably in excess of similar ICF's-MR in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider. All expenses reported as central office cost shall be limited to the actual client-related costs of the central office.

(b) Expense limitations.

(1) Salaries of professionally qualified employees performing the duties for which they are professionally qualified shall be allocated to the room and board and health care cost centers as appropriate for the duties performed. Professionally qualified employees include licensed and registered nurses, dietitians, qualified mental retardation professionals, and other as may be designated by the secretary.

(2) Salaries of chief executives, corporate officers, department heads, and employees with ownership interests of 5% or more shall be considered owner's compensation and shall be reported as owner's compensation in the administrative cost center. Salaries of the chief executive officers of non-profit organizations shall also be considered owner's compensation and included in the administrative cost center.

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(3) The salary of an owner or related party performing a client-related service for which such person is professionally qualified shall be included in the appropriate cost center for that service.

(4) Salaries of all other central office personnel performing client-related administrative functions shall be reported in the administrative cost center.

(5) All providers operating more than one facility shall complete and submit detailed schedules of all salaries and expenses incurred for each fiscal year. Failure to submit detailed central office expenses and allocation methods shall result in the cost report being considered incomplete. Methods for allocating all program costs to all facilities in this and other states shall be submitted for prior approval. Changes in these methods shall not be permitted without prior approval.

(6) A central office cost limit may be established by the agency within the overall administrative cost center limit.  
(Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T- 30-12-28-90, Dec. 28, 1990 ; effective P- March 4, 1991 .)

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30-10-225. ICF-MR client days. (a) Calculation of client days.

- (1) Client day has the meaning set forth in K.A.R. 30-10-200.
- (2) If both admission and discharge occur on the same day, that day shall be considered to be a day of admission and shall count as one client day.
- (3) If the provider does not make refunds on behalf of a client for unused days in case of death or discharge, and if the bed is available and actually used by another client, these unused days shall not be counted as a client day.
- (4) Any bed days paid for by the client, or any other party on behalf of the client, before an admission date shall not be counted as a client day.
- (5) The total client days for the cost report period shall be precise and documented; an estimate of the days of care provided shall not be acceptable.
- (6) In order to facilitate accurate and uniform reporting of client days, the accumulated method format set forth in forms prescribed by the secretary shall be used for all clients. These forms shall be submitted to the agency as supportive documentation for the client days shown on the cost report forms and shall be submitted at the time the cost report forms are submitted to the agency. Each provider shall keep these monthly records for each client, whether a medicaid/medikan recipient or a non-recipient. If a provider fails to keep accurate records of client days in

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accordance with the accumulated method format, the assumed occupancy rate shall be 100%.

(7) The provider shall report the total number of medicaid/medikan client days in addition to the total client days on the uniform cost report form.

(b) Any provider which has an occupancy rate of less than 90% for the cost report period shall calculate client days at a minimum occupancy of 90%.

(c) The minimum occupancy rate shall be determined by multiplying the total licensed bed days available by 90%. Therefore, in order to participate in the medicaid/medikan program, each ICF-MR provider shall obtain proper certification for all licensed beds.

(d) Respite care days shall be counted as client days and reported on the monthly census forms.

(e) Day care and day treatment shall be counted as one client day for 18 hours of service. The total hours of service provided for all clients during the cost reporting year shall be divided by 18 hours to convert to client days. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T- 30-12-28-90, Dec. 28, 1990 ; effective P- March 4, 1991 .)

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This section reserved for future use.

**KANSAS MEDICAID STATE PLAN**

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Part II

Subpart **BB**

~~BB~~

**Methods and Standards for Establishing Payment Rates-  
Skilled Nursing and Intermediate Care Facility Rates**

**(ICFs/MR)**

**Appeal Procedures**

Pursuant to 42 CFR 447.253(c) the State Medicaid Agency in accordance with federal regulations and with state statutes and regulations provides a fair hearing procedure that allows for an administrative review and an appeal by the ICF/MR as to its payment rates before the Administrative Hearings Section of the agency. The appeals procedures are defined in the Kansas Statutes Annotated and Kansas Administrative Regulations.

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SOCIAL AND REHABILITATION SERVICES

75-3306

mental clinics. The director of mental health and retardation services, in cooperation with the secretary of health and environment, and with the approval of the secretary of social and rehabilitation services, may assist a county in the establishment of outpatient mental health treatment centers or clinics by providing personnel in accordance with rules and regulations adopted by the secretary of social and rehabilitation services.

History: L. 1957, ch. 346, § 1; L. 1973, ch. 369, § 40; L. 1975, ch. 462, § 119; July 1.

**75-3304.** Rules and regulations concerning social welfare. The secretary of social and rehabilitation services may adopt rules and regulations relating to all forms of social welfare.

History: L. 1939, ch. 202, § 4; L. 1949, ch. 446, § 9; L. 1953, ch. 391, § 7; L. 1973, ch. 369, § 41; July 1.

Source or prior law:  
39-705.

Research and Practice Aids:  
Social Security and Public Welfare - 5.  
C.J.S. Social Security and Public Welfare § 9.

**75-3304a.** Responsibility for mental health program. The secretary of social and rehabilitation services is hereby designated as the state agency charged with the administration of the mental health program of the state of Kansas, and such secretary shall have primary responsibility for the state's mental health program, including preventive mental hygiene activities.

History: L. 1961, ch. 403, § 1; L. 1973, ch. 369, § 42; July 1.

Attorney General's Opinions:  
Licensing, inspection and regulation; licensure of psychiatric hospitals. 86-58.

**75-3304b.** Transfer of certain lands from board of social welfare to board of regents. L. 1967, ch. 468, § 1, included by reference. [Transferred certain described state owned lands from jurisdiction and control of the state board of social welfare to the state board of regents.]

History: L. 1967, ch. 468, § 1; July 1.

**75-3305.**

History: L. 1939, ch. 202, § 5; L. 1949, ch. 446, § 10; L. 1953, ch. 391, § 8; Repealed, L. 1967, ch. 434, § 69; July 1.

Source or prior law:  
39-707.

**75-3306.** Appeals to secretary; investigations; subpoenas; hearings, when required; application of Kansas administrative procedure act, exceptions; jurisdiction. (a) The secretary of social and rehabilitation services, except as set forth in the Kansas administrative procedure act and subsections (f), (g), (h) and (i), shall provide a fair hearing for any person who is an applicant, client, inmate, other interested person or taxpayer who appeals from the decision or final action of any agent or employee of the secretary. The hearing shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

It shall be the duty of the secretary of social and rehabilitation services to have available in all intake offices, during all office hours, forms for filing complaints for hearings, and appeal forms with which to appeal from the decision of the agent or employee of the secretary. The forms shall be prescribed by the secretary of social and rehabilitation services and shall have printed on or as a part of them the basic procedure for hearings and appeals prescribed by state law and the secretary of social and rehabilitation services.

(b) The secretary of social and rehabilitation services shall have authority to investigate (1) any claims and vouchers and persons or businesses who provide services to the secretary of social and rehabilitation services or to welfare recipients, (2) the eligibility of persons to receive assistance and (3) the eligibility of providers of services.

(c) The secretary of social and rehabilitation services shall have authority, when conducting investigations as provided for in this section, to issue subpoenas; compel the attendance of witnesses at the place designated in this state; compel the production of any records, books, papers or other documents considered necessary; administer oaths; take testimony; and render decisions. If a person refuses to comply with any subpoena issued under this section or to testify to any matter regarding which the person may lawfully be questioned, the district court of any county, on application of the secretary, may issue an order requiring the person to comply with the subpoena and to testify, and any failure to obey the order of the court may be punished by the court as a contempt of court. Unless incapacitated, the person placing a claim or defending a privilege before the secretary shall appear in person or by authorized representative and may not be excused from answering questions and supplying infor-

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**75-3307 STATE DEPARTMENTS; PUBLIC OFFICERS AND EMPLOYEES**

mation, except in accordance with the person's constitutional rights and lawful privileges.

(d) The presiding officer may close any portion of a hearing conducted under the Kansas administrative procedure act when matters made confidential, pursuant to federal or state law or regulation are under consideration.

(e) Except as provided in subsection (d) of K.S.A. 77-511 and amendments thereto and notwithstanding the other provisions of the Kansas administrative procedure act, the secretary may enforce any order prior to the disposition of a person's application for an adjudicative proceeding unless prohibited from such action by federal or state statute, regulation or court order.

(f) Decisions relating to the administration of the support enforcement program set forth in K.S.A. 39-753 *et seq.* and amendments thereto except for federal debt set-off activities shall be exempt from the provisions of the Kansas administrative procedure act and subsection (a).

(g) Decisions relating to administrative disqualification hearings shall be exempt from the provisions of the Kansas administrative procedure act and subsection (a).

(h) The department of social and rehabilitation services shall not have jurisdiction to determine the facial validity of a state or federal statute. The administrative hearings section of the department of social and rehabilitation services shall not have jurisdiction to determine the facial validity of an agency rule and regulation.

(i) The department of social and rehabilitation services shall not be required to provide a hearing if: (1) The department of social and rehabilitation services lacks jurisdiction of the subject matter; (2) resolution of the matter does not require the department of social and rehabilitation services to issue an order that determines the applicant's legal rights, duties, privileges, immunities or other legal interests; (3) the matter was not timely submitted to the department of social and rehabilitation services pursuant to regulation or other provision of law; or (4) the matter was not submitted in a form substantially complying with any applicable provision of law.

History: L. 1939, ch. 202, § 6; L. 1947, ch. 425, § 7; L. 1949, ch. 447, § 1; L. 1972, ch. 325, § 1; L. 1973, ch. 186, § 33; L. 1984, ch. 320, § 1; L. 1988, ch. 356, § 302; L. 1989, ch. 283, § 21; July 1.

Source or prior law:  
30-704.

Law Review and Bar Journal References:  
"Rethinking Kansas Administrative Procedure," Marilynn V. Alarworth and Sidney A. Shapiro, 28 K.L.R. 419, 435 (1980).

Attorney General's Opinions:  
Constitutionality of 65-516(a)(3); child abuse validation by the department of social and rehabilitation services. 80-163.

**CASE ANNOTATIONS**

1. Application to appeal by county board of social welfare questioned. State, ex rel., v. Jackson County Board of Social Welfare, 161 K. 672, 681, 171 P.2d 651.

2. Venue of appeal from order of state appeals committee of state department of social welfare is in Wyandotte county. Powers v. State Department of Social Welfare, 206 K. 605, 609, 483 P.2d 500.

3. Order of state appeals committee of state department of social welfare denying welfare benefits is judicial or quasi-judicial in nature. Powers v. State Department of Social Welfare, 206 K. 605, 610, 493 P.2d 590.

4. Cited, section provides proper remedy for persons deprived of rights under social welfare act. Valkenburgh v. State Board of Social Welfare, 211 K. 754, 757, 508 P.2d 875.

5. Referred to in upholding appeal to supreme court from ruling by district court on administrative decision; scope of review. Olathe Hospital Foundation, Inc. v. Es-tendicare, Inc., 217 K. 546, 550, 539 P.2d 1.

6. Determination of whether Kansas resident who receives care in another state is eligible for medical assistance under 39-706 Elliott v. State Dept. of Social & Rehab. Serv., 3 K.A.2d 484, 597 P.2d 678.

**75-3307.** Real estate of institutions; custody of deeds in secretary of state; control of lands in secretary of social and rehabilitation services; lease of surplus real estate. All deeds or other documents pertaining to titles to real estate in connection with institutions as defined in K.S.A. 76-12a01 shall be placed and remain in the custody of the secretary of state. The secretary of social and rehabilitation services shall have custody and control of such land and the same shall belong to the state of Kansas. The secretary of social and rehabilitation services may enter into lease agreements for real estate surplus to the immediate or long term need of any such institution.

History: L. 1939, ch. 202, § 7; L. 1949, ch. 446, § 11; L. 1953, ch. 375, § 65; L. 1963, ch. 254, § 1; L. 1969, ch. 425, § 1; L. 1972, ch. 326, § 1; L. 1973, ch. 369, § 31; L. 1973, ch. 370, § 1; July 1.

Cross References to Related Sections:  
Secretary of social and rehabilitation services, see 75-3301.

Research and Practice Aids:  
Admission to hospital, Kansas Probate Law and Practice § 1116.

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**77-501 STATUTES; ADMIN. RULES AND REGULATIONS; PROCEDURES**

**Attorney General's Opinions:**

Parimutuel racing; refund of deposit of unsuccessful applicant for license; setoffs. 88-120.

**GENERAL PROVISIONS**

**Law Review and Bar Journal References:**

"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 56 (1985).

**77-501.** Title. K.S.A. 1985 Supp. 77-501 through 77-541 shall be known and may be cited as the Kansas administrative procedure act.

History: L. 1984, ch. 313, § 1; July 1, 1985.

**CASE ANNOTATIONS**

1. Act creates only procedural rights and imposes only procedural duties. *Expert Environmental Control, Inc. v. Walker*, 13 K.A.2d 56, 57, 761 P.2d 320 (1988).

2. Provisions of act not applicable to decisions and actions of Kansas racing commission regarding issuance of licenses (74-8801 et seq.). *Kansas Racing Management, Inc. v. Kansas Racing Comm'n*, 244 K. 343, 347, 364, 770 P.2d 423 (1989).

**77-502.** Definitions. As used in this act:

(a) "State agency" means any officer, department, bureau, division, board, authority, agency, commission or institution of this state, except the judicial and legislative branches of state government and political subdivisions of the state, which is authorized by law to administer, enforce or interpret any law of this state.

(b) "Agency head" means an individual or body of individuals in whom the ultimate legal authority of the state agency is vested by any provision of law.

(c) "License" means a franchise, permit, certification, approval, registration, charter or similar form of authorization required by law for a person to engage in a profession or occupation.

(d) "Order" means a state agency action of particular applicability that determines the legal rights, duties, privileges, immunities or other legal interest of one or more specific persons.

(e) "Party to state agency proceedings," or "party" in context so indicating, means:

(1) A person to whom an order is specifically directed; or

(2) a person named as a party to a state agency proceeding or allowed to intervene as a party in the proceeding.

(f) "Person" means an individual, partnership, corporation, association, political subdivision or unit thereof or public or private organization or entity of any character, and includes another state agency.

(g) "Political subdivision" means political or taxing subdivisions of the state, including boards, commissions, authorities, councils, committees, subcommittees and other subordinate groups or administrative units thereof, receiving or expending and supported in whole or in part by public funds.

History: L. 1984, ch. 313, § 2; L. 1988, ch. 356, § 1; July 1, 1989.

**77-503.** Application and construction. (a) This act applies only to the extent that other statutes expressly provide that the provisions of this act govern proceedings under those statutes.

(b) This act creates only procedural rights and imposes only procedural duties. They are in addition to those created and imposed by other statutes.

History: L. 1984, ch. 313, § 3; July 1, 1985.

**Law Review and Bar Journal References:**

"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 56 (1985).

**CASE ANNOTATIONS**

1. Act creates only procedural rights and imposes only procedural duties. *Expert Environmental Control, Inc. v. Walker*, 13 K.A.2d 56, 57, 761 P.2d 320 (1988).

**77-504.** Waiver. Except to the extent precluded by another provision of law, a person may waive any right conferred upon that person by this act.

History: L. 1984, ch. 313, § 4; July 1, 1985.

**77-505.** Informal settlements. Nothing in this act shall preclude informal settlement of matters that may make unnecessary more elaborate proceedings under this act.

History: L. 1984, ch. 313, § 5; July 1, 1985.

**77-506.** Conversion of proceedings. (a) At any point in a state agency proceeding the presiding officer or other state agency official responsible for the proceeding:

(1) May convert the proceeding to another type of state agency proceeding if the conversion is appropriate, is in the public interest and does not substantially prejudice the rights of any party; and

(2) if required by any provision of law, shall convert the proceeding to another type of state agency proceeding.

(b) A conversion of a proceeding of one type to a proceeding of another type may be effected only upon notice to all parties to the original proceeding.

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(c) If the presiding officer or other state agency official responsible for the original proceeding would not have authority over the new proceeding to which it is to be converted, that officer or official, in accordance with state agency procedure, shall secure the appointment of a successor to preside over or be responsible for the new proceeding.

(d) The record of the original state agency proceeding may be used in the new state agency proceeding.

(e) After a proceeding is converted from one type to another, the presiding officer or other state agency official responsible for the new proceeding shall:

(1) Give such additional notice to parties or other persons as is necessary to satisfy the requirements pertaining to those proceedings;

(2) dispose of the matters involved without further proceedings if sufficient proceedings have already been held to satisfy the requirements pertaining to the new proceedings; and

(3) conduct or cause to be conducted any additional proceedings necessary to satisfy the requirements pertaining to those proceedings.

History: L. 1984, ch. 313, § 6; L. 1986, ch. 356, § 2; July 1, 1989.

Law Review and Bar Journal References:  
 "The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57 (1985).

**77-507.** Effective date of act. This act shall take effect on July 1, 1985, and does not govern adjudicative proceedings pending on that date. Subject to K.S.A. 1985 Supp. 77-503, this act governs all state agency adjudicative proceedings commenced after that date. This act also governs state agency adjudicative proceedings conducted on a remand from a court or another state agency after the effective date of this act.

History: L. 1984, ch. 313, § 7; July 1, 1985.

**77-507a.** Effective date of 1988 act. This act shall take effect on July 1, 1989, and does not govern adjudicative proceedings pending on that date. Subject to K.S.A. 77-503 and amendments thereto, this act governs all state agency adjudicative proceedings commenced after that date. This act also governs state agency adjudicative proceedings conducted on a remand from a court or another state agency after the effective date of this act.

History: L. 1988, ch. 356, § 360; July 1, 1989.

**77-508.** Hearings, not required in certain circumstances. A hearing shall not be required for a decision:

(a) To issue or not to issue a complaint, summons or similar accusation; or

(b) to initiate or not to initiate an investigation, prosecution or other proceeding before the state agency, another agency or a court.

History: L. 1984, ch. 313, § 6; L. 1986, ch. 356, § 3; L. 1989, ch. 283, § 1; July 1.

Law Review and Bar Journal References:  
 "The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57 (1985).

**77-509.**

History: L. 1984, ch. 313, § 9; L. 1986, ch. 362, § 1; L. 1988, ch. 356, § 4; Repealed, L. 1989, ch. 283, § 26; July 1.

**77-510.**

History: L. 1984, ch. 313, § 10; Repealed, L. 1989, ch. 283, § 26; July 1.

**77-511.** Time limits for processing application for an order or a request for a hearing; expiration of license, when. (a) Except to the extent that the time limits in this subsection are inconsistent with limits established by another statute, a state agency shall process an application for an order on which a statute provides for a hearing under this act as follows:

(1) Within 30 days after receipt of the application, the state agency shall acknowledge receipt thereof and inform the applicant of the name, official title, mailing address and telephone number of a state agency member or employee who may be contacted regarding the application. As soon as practicable, the state agency shall notify the applicant of any apparent errors or omissions. Failure to detect such errors or omissions does not preclude the state agency from raising them at a later stage of the proceeding.

(2) When practicable, within 90 days after receipt of a completed application, the state agency shall:

(A) Approve or deny the application, in whole or in part, on the basis of emergency or summary proceedings, if those proceedings are available under this act for disposition of the matter; or

(B) commence a formal hearing or a conference hearing in accordance with this act.

(b) Except to the extent that the time limits in this subsection are inconsistent with limits established by another statute, a state agency shall process a request for a hearing as follows:

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(1) Within 30 days after receipt of the request, the state agency shall acknowledge receipt thereof and if the state agency has not previously done so, the state agency shall notify the applicant of the name, official title, mailing address and telephone number of a state agency member or employee who may be contacted regarding the request; and

(2) when practicable, within 90 days after receipt of the request the state agency shall commence a formal or conference hearing in accordance with this act unless a statute makes the granting of a hearing discretionary with the state agency and the state agency determines not to conduct a hearing.

(c) A hearing commences when the state agency or presiding officer notifies a party that a prehearing conference or other stage of the hearing will be conducted.

(d) If a timely and sufficient application has been made for renewal of a license with reference to any activity of a continuing nature, the existing license does not expire until the state agency has taken final action upon the application for renewal or, if the state agency's action is unfavorable, until the last day for seeking judicial review of the state agency's action or a later date fixed by the reviewing court.

History: L. 1984, ch. 313, § 11; L. 1986, ch. 362, § 2; L. 1988, ch. 356, § 5; L. 1989, ch. 283, § 2; July 1.

77-512. Orders affecting licensure; requirements. A state agency may not revoke, suspend, modify, annul, withdraw, refuse to renew, or amend a license unless the state agency first gives notice and an opportunity for a hearing in accordance with this act. This section does not preclude a state agency from (a) taking immediate action to protect the public interest in accordance with K.S.A. 77-536, and amendments thereto, or (b) adopting rules and regulations, otherwise within the scope of its authority, pertaining to a class of licensees, including rules and regulations affecting the existing licenses of a class of licensees.

History: L. 1984, ch. 313, § 12; L. 1989, ch. 283, § 3; July 1.

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77-513. Hearings, applicable procedures. When a statute provides for a hearing in accordance with this act, the hearing shall be governed by K.S.A. 77-513 through 77-532, and amendments thereto, except as otherwise provided by:

- (a) A statute other than this act, or
  - (b) K.S.A. 77-533 through 77-541, and amendments thereto
- History: L. 1984, ch. 313, § 13; L. 1986, ch. 362, § 3; L. 1988, ch. 356, § 6; L. 1989, ch. 283, § 4; July 1.

Law Review and Bar Journal References:  
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57 (1985).

77-514. Presiding officer. (a) The agency head or one or more other persons designated by the agency head may be the presiding officer.

(b) Any person serving or designated to serve alone or with others as presiding officer is subject to disqualification for administrative bias, prejudice or interest.

(c) Any party may petition for the disqualification of a person promptly after receipt of notice indicating that the person will preside or promptly upon discovering facts establishing grounds for disqualification, whichever is later.

(d) A person whose disqualification is requested shall determine whether to grant the petition, stating facts and reasons for the determination.

(e) If a substitute is required for a person who is disqualified or becomes unavailable for any other reason, any action taken by a duly appointed substitute for a disqualified or unavailable person is as effective as if taken by the latter.

(f) A state agency may enter into agreements with another state agency to provide hearing officers to conduct proceedings under this act or for other agency proceedings.

History: L. 1984, ch. 313, § 14; July 1, 1985.

77-515. Participation and representation. (a) Any party may participate in the hearing in person or, if the party is a corporation or other artificial person, by a duly authorized representative.

(b) Whether or not participating in person, any party may be represented at the party's own expense by counsel or, if permitted by law, other representative.

(c) A state agency may require a corporation or other artificial person to participate by counsel.

History: L. 1984, ch. 313, § 15; L. 1986, ch. 362, § 4; July 1.

77-516. Prehearing conference; notice. The presiding officer designated to conduct the

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hearing may conduct a prehearing conference. If the conference is conducted:

(a) The state agency may assign a presiding officer for the prehearing conference, exercising the same discretion as is provided by K.S.A. 77-514 and amendments thereto concerning the selection of a presiding officer for a hearing.

(b) The presiding officer for the prehearing conference shall set the time and place of the conference and give reasonable notice to all parties and to all persons who have filed written petitions to intervene in the matter.

(c) The notice shall include:

(1) The names and mailing addresses of all parties and other persons to whom notice is being given by the presiding officer;

(2) the name, official title, mailing address and telephone number of any counsel or employee who has been designated to appear for the state agency;

(3) the official file or other reference number, the name of the proceeding and a general description of the subject matter;

(4) a statement of the time, place and nature of the prehearing conference;

(5) a statement of the legal authority and jurisdiction under which the prehearing conference and the hearing are to be held;

(6) the name, official title, mailing address and telephone number of the presiding officer for the prehearing conference;

(7) a statement that at the prehearing conference the proceeding, without further notice, may be converted into a conference hearing or a summary proceeding for disposition of the matter as provided by this act; and

(8) a statement that a party who fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative proceeding may be held in default under this act.

(d) The notice may include any other matters that the presiding officer considers desirable to expedite the proceedings.

History: L. 1984, ch. 313, § 16; L. 1988 ch. 356, § 7; July 1, 1989.

**77-517. Prehearing conference; procedure; prehearing order.** (a) The presiding officer may conduct all or part of the prehearing conference by telephone or other electronic means if each participant in the conference has an opportunity to participate in the entire proceeding while it is taking place.

(b) The presiding officer shall conduct the prehearing conference, as may be appropriate, to deal with such matters as conversion of the proceeding to another type, exploration of settlement possibilities, preparation of stipulations, clarification of issues, rulings on identity and limitation of the number of witnesses, objections to proffers of evidence, determination of the extent to which direct evidence, rebuttal evidence, or cross-examination will be presented in written form, and the extent to which telephone or other electronic means will be used as a substitute for proceedings in person, order of presentation of evidence and cross-examination, rulings regarding issuance of subpoenas, discovery orders and protective orders and such other matters as will promote the orderly and prompt conduct of the hearing. The presiding officer shall issue a prehearing order incorporating the matters determined at the prehearing conference.

(c) If a prehearing conference is not held, the presiding officer for the hearing may issue a prehearing order, based on the pleadings, to regulate the conduct of the proceedings.

History: L. 1984, ch. 313, § 17; July 1, 1985.

**77-518. Notice of hearing.** (a) The state agency shall set the time and place of the hearing and give reasonable written notice at least 10 days prior to the hearing to all parties and to all persons who have filed written petitions to intervene in the matter. Service of notices shall be made in accordance with K.S.A. 77-531 and amendments thereto.

(b) The notice shall include a copy of any prehearing order rendered in the matter.

(c) To the extent not included in a prehearing order accompanying it, the notice shall include:

(1) The names and mailing addresses of all parties and other persons to whom notice is being given by the presiding officer;

(2) the name, official title, mailing address and telephone number of any counsel or employee who has been designated to appear for the state agency;

(3) the official file or other reference number, the name of the proceeding and a general description of the subject matter;

(4) a statement of the time, place and nature of the hearing;

(5) a statement of the legal authority and jurisdiction under which the hearing is to be held;

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(6) the name, official title, mailing address and telephone number of the presiding officer;

(7) a statement of the issues involved and, to the extent known to the presiding officer, of the matters asserted by the parties; and

(8) a statement that a party who fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative proceeding may be held in default under this act.

(d) The notice may include any other matters the presiding officer considers desirable to expedite the proceedings.

(e) The state agency shall cause notice to be given to persons entitled to notice under any provision of law who have not been given notice under subsection (a). Notice under this subsection shall be given in the manner specified by such provision of law or, if no such manner is specified, in a manner to be determined by the agency. If a person other than the agency is directed to give notice under this subsection, the agency shall require that the person furnish proof that the notice has been given. Notice under this subsection may include all types of information provided in subsections (a) through (d) or may consist of a brief statement indicating the subject matter, parties, time, place and nature of the hearing, manner in which copies of the notice to the parties may be inspected and copied and name and telephone number of the presiding officer.

History: L. 1984, ch. 313, § 18; L. 1988, ch. 356, § 8; July 1, 1989.

Law Review and Bar Journal References:  
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 59 (1985).

**77-519. Pleadings, motions, briefs; service.** (a) The presiding officer, at appropriate stages of the proceedings, shall give all parties full opportunity to file pleadings, motions and objections.

(b) The presiding officer, at appropriate stages of the proceedings, may give all parties full opportunity to file briefs, proposed findings of fact and conclusions of law and proposed initial or final orders.

(c) A party shall serve copies of any filed item on all parties, by mail or any other means prescribed by state agency rule and regulation.

History: L. 1984, ch. 313, § 19; L. 1986, ch. 362, § 5; July 1.

**77-520. Default.** (a) If a party fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative pro-

ceeding, the presiding officer may serve upon all parties written notice of a proposed default order, including a statement of the grounds.

(b) Within seven days after service of a proposed default order, the party against whom it was issued may file a written motion requesting that the proposed default order be vacated and stating the grounds relied upon. During the time within which a party may file a written motion under this subsection, the presiding officer may adjourn the proceedings or conduct them without the participation of the party against whom a proposed default order was issued, having due regard for the interests of justice and the orderly and prompt conduct of the proceedings.

(c) Unless vacated by the presiding officer, the proposed default order shall become effective after expiration of the time within which the party may file a written motion under subsection (b).

(d) After a default order becomes effective, the presiding officer shall conduct any further proceedings necessary to complete the adjudication without the participation of the party in default and shall determine all issues in the adjudication, including those affecting the defaulting party. The presiding officer in lieu of determining the issues affecting the defaulting party may, unless otherwise prohibited by law, dismiss such party's application for an adjudicative proceeding.

History: L. 1984, ch. 313, § 20; L. 1986, ch. 362, § 6; L. 1988, ch. 356, § 9, July 1, 1989.

**77-521. Intervention.** (a) The presiding officer shall grant a petition for intervention if:

(1) The petition is submitted in writing to the presiding officer, with copies mailed to all parties named in the presiding officer's notice of the hearing, at least three days before the hearing;

(2) the petition states facts demonstrating that the petitioner's legal rights, duties, privileges, immunities or other legal interests may be substantially affected by the proceeding or that the petitioner qualifies as an intervener under any provision of law; and

(3) the presiding officer determines that the interests of justice and the orderly and prompt conduct of the proceedings will not be impaired by allowing the intervention.

(b) The presiding officer may grant a petition for intervention at any time upon determining that the intervention sought is in the

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interests of justice and will not impair the orderly and prompt conduct of the proceedings.

(c) If a petitioner qualifies for intervention, the presiding officer may impose conditions upon the intervenor's participation in the proceedings, either at the time that intervention is granted or at any subsequent time. Conditions may include:

(1) Limiting the intervenor's participation to designated issues in which the intervenor has a particular interest demonstrated by the petition;

(2) limiting the intervenor's use of discovery, cross-examination and other procedures so as to promote the orderly and prompt conduct of the proceedings; and

(3) requiring two or more intervenors to combine their presentations of evidence and argument, cross-examination, discovery and other participation in the proceedings.

(d) The presiding officer, at least 24 hours before the hearing, shall issue an order granting or denying each pending petition for intervention, specifying any conditions and briefly stating the reasons for the order. The presiding officer may modify the order at any time, stating the reasons for the modification. The presiding officer shall promptly give notice of an order granting, denying or modifying intervention to the petitioner for intervention and to all parties.

History: L. 1984, ch. 313, § 21; July 1, 1985.

**77-522. Discovery; authorization; requests; subpoenas, discovery orders and protective orders.** (a) Discovery shall be permitted to the extent allowed by the presiding officer or as agreed to by the parties. Requests for discovery shall be made in writing to the presiding officer and a copy of each request for discovery shall be served on the party or person against whom discovery is sought. The presiding officer may specify the times during which the parties may pursue discovery and respond to discovery requests. The presiding officer may issue subpoenas, discovery orders and protective orders in accordance with the rules of civil procedure.

(b) Subpoenas issued by the presiding officer shall be served by a person designated by the presiding officer or any other person who is not a party and is not less than 18 years of age. Service shall be in person and at the expense of the requesting party. Proof of service shall be shown by affidavit.

(c) Subpoenas and orders issued by the presiding officer may be enforced pursuant to the provisions of the act for judicial review and civil enforcement of agency actions.

History: L. 1984, ch. 313, § 22; L. 1988, ch. 356, § 10; L. 1989, ch. 283, § 5; July 1.

**77-523. Hearing procedure.** At a hearing:

(a) The presiding officer shall regulate the course of the proceedings.

(b) To the extent necessary for full disclosure of all relevant facts and issues, the presiding officer shall afford to all parties the opportunity to respond, present evidence and argument, conduct cross-examination and submit rebuttal evidence, except as restricted by a limited grant of intervention or by the pre-hearing order.

(c) The presiding officer may, and when required by statute shall, give nonparties an opportunity to present oral or written statements. If the presiding officer proposes to consider a statement by a nonparty, the presiding officer shall give all parties an opportunity to challenge or rebut it and, on motion of any party, the presiding officer shall require the statement to be given under oath or affirmation.

(d) The presiding officer may conduct all or part of the hearing by telephone or other electronic means, if each participant in the hearing has an opportunity to participate in the entire proceeding while it is taking place.

(e) The presiding officer shall cause the hearing to be recorded at the state agency's expense. The state agency is not required, at its expense, to prepare a transcript, unless required to do so by a provision of law. Any party, at the party's expense and subject to such reasonable conditions as the state agency may establish, may cause a person other than the state agency to prepare a transcript from the state agency's record, or cause additional recordings to be made during the hearing.

(f) The hearing is open to public observation, except for the parts that the presiding officer states to be closed pursuant to a provision of law expressly authorizing closure.

History: L. 1984, ch. 313, § 23; L. 1988, ch. 356, § 11; July 1, 1989.

Law Review and Bar Journal References:  
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 84 J.K.B.A. 53, 59 (1993).

**77-524. Evidence; official notice.** (a) A presiding officer need not be bound by technical rules of evidence, but shall give the par-

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ties reasonable opportunity to be heard and to present evidence, and the presiding officer shall act reasonably without partiality. The presiding officer shall give effect to the rules of privilege recognized by law. Evidence need not be excluded solely because it is hearsay.

(b) All testimony of parties and witnesses shall be made under oath or affirmation and the presiding officer shall have the power to administer an oath or affirmation for that purpose.

(c) Statements presented by nonparties in accordance with paragraph (c) of K.S.A. 1985 Supp. 77-523 may be received as evidence.

(d) Any part of the evidence may be received in written form if doing so will expedite the hearing without substantial prejudice to the interests of any party.

(e) Documentary evidence may be received in the form of a copy or excerpt. Upon request, parties shall be given an opportunity to compare the copy with the original if available.

(f) Official notice may be taken of (1) any matter that could be judicially noticed in the courts of this state, (2) the record of other proceedings before the state agency, (3) technical or scientific matters within the state agency's specialized knowledge, and (4) codes of standards that have been adopted by an agency of the United States, of this state or of another state or by a nationally recognized organization or association. Parties shall be notified before or during the hearing, or before the issuance of any initial or final order that is based in whole or in part on matters or material noticed, of the specific matters or material noticed and the source thereof, including any staff memoranda and data, and be afforded an opportunity to contest and rebut the matters or material so noticed.

History: L. 1984, ch. 313, § 24; July 1, 1985.

**77-525. Ex parte communications; exemption for certain agencies.** (a) A presiding officer serving in an adjudicative proceeding may not communicate, directly or indirectly, regarding any issue in the proceeding while the proceeding is pending, with any party or participant, with any person who has a direct or indirect interest in the outcome of the proceeding or with any person who presided at a previous stage of the proceeding, without notice and opportunity for all parties to participate in the communication.

(b) A member of a multimember panel presiding officers may communicate with other members of the panel regarding a matter pending before the panel, and any presiding officer may receive aid from staff assistants if the assistants do not:

(1) Receive *ex parte* communications of a type that the presiding officer would be prohibited from receiving; or

(2) furnish, augment, diminish or modify the evidence in the record.

(c) Unless required for the disposition of *ex parte* matters specifically authorized by statute, no party to an adjudicative proceeding, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the proceeding, may directly or indirectly communicate in connection with any issue in that proceeding, while the proceeding is pending, with any person serving as presiding officer unless notice and an opportunity are given all parties to participate in the communication.

(d) If, before serving as presiding officer in an adjudicative proceeding, a person receives an *ex parte* communication of a type that could not properly be received while serving, the person, promptly after starting to serve, shall disclose the communication in the manner prescribed in subsection (e).

(e) A presiding officer who receives an *ex parte* communication in violation of this section shall place on the record of the pending matter all written communications received, all written responses to the communications and a memorandum stating the substance of all oral communications received, all responses made, and the identity of each person from whom the presiding officer received an *ex parte* communication and shall advise all parties that these matters have been placed on the record. Any party desiring to rebut the *ex parte* communication must be allowed to do so, upon requesting the opportunity for rebuttal within 10 days after notice of the communication.

(f) If necessary to eliminate the effect of an *ex parte* communication received in violation of this section, a presiding officer who receives the communication may be disqualified and the portions of the record pertaining to the communication may be sealed by protective order.

(g) The state agency shall, and any party may, report any willful violation of this section to appropriate authorities for any disciplinary proceedings provided by law. In addition, each state agency, by rule and regulation, may pre-

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vide for appropriate sanctions, including default, for any violations of this section.

(h) This section shall not apply to adjudicative proceedings before:

(1) The state corporation commission. Such proceedings shall be subject to the provisions of K.S.A. 77-545;

(2) the commissioner of insurance concerning any rate, or any rule, regulation or practice pertaining to the rates over which the commissioner has jurisdiction or adjudicative proceedings held pursuant to the Kansas insurance holding companies act. Such proceedings shall be subject to the provisions of K.S.A. 77-546; and

(3) the director of taxation. Such proceedings shall be subject to the provisions of K.S.A. 77-548.

History: L. 1984, ch. 313, § 25; L. 1986, ch. 352, § 7; L. 1988, ch. 356, § 12; July 1, 1989.

**77-526.** Orders, initial and final; exception for state corporation commission. (a) If the presiding officer is the agency head, the presiding officer shall render a final order.

(b) If the presiding officer is not the agency head, the presiding officer shall render an initial order, which becomes a final order unless reviewed in accordance with K.S.A. 77-527 and amendments thereto.

(c) A final order or initial order shall include, separately stated, findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, for all aspects of the order, including the remedy prescribed and, if applicable, the action taken on a petition for stay of effectiveness. Findings of fact, if set forth in language that is no more than mere repetition or paraphrase of the relevant provision of law, shall be accompanied by a concise and explicit statement of the underlying facts of record to support the findings. The order shall also include a statement of the available procedures and time limits for seeking reconsideration, administrative review or other administrative relief. An initial order shall include a statement of any circumstances under which the initial order, without further notice, may become a final order.

(d) Findings of fact shall be based exclusively upon the evidence of record in the adjudicative proceeding and on matters officially noticed in that proceeding.

(e) If a substitute presiding officer is appointed pursuant to K.S.A. 77-514 and amendments thereto, the substitute presiding officer shall use any existing record and may conduct any further proceedings appropriate in the interests of justice.

(f) The presiding officer may allow the parties a designated amount of time after conclusion of the hearing for the submission of proposed findings.

(g) A final order or initial order pursuant to this section shall be rendered in writing and served within 30 days after conclusion of the hearing or after submission of proposed findings in accordance with subsection (f) unless this period is waived or extended with the written consent of all parties or for good cause shown.

(h) The presiding officer shall cause copies of the order to be served on each party and, if the order is an initial order, on the agency head in the manner prescribed by K.S.A. 77-531 and amendments thereto.

(i) Notwithstanding the other provisions of this section, if the presiding officer in a hearing before the state corporation commission is not the agency head, the presiding officer shall not render an initial order but shall make written findings and recommendations to the commission. The commission shall render and serve a final order within 60 days after conclusion of the hearing or after submission of proposed findings in accordance with subsection (f) unless this period is waived or extended with the written consent of all parties or for good cause shown.

History: L. 1984, ch. 313, § 26; L. 1988, ch. 356, § 13; July 1, 1989.

Law Review and Bar Journal References:  
 "The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 60 (1985).

CASE ANNOTATIONS

1. Failure to render final or initial order does not deprive agency of jurisdiction. *Expert Environmental Control, Inc. v. Walker*, 13 K.A.2d 56, 58, 761 P.2d 320 (1988).

**77-527.** Review of initial order; exceptions to reviewability. (a) The agency head, upon its own motion may, and upon petition by any party or when required by law shall, review an initial order, except to the extent that:

(1) A provision of law precludes or limits state agency review of the initial order; or

(2) the agency head (A) determines to review some but not all issues, or not to exercise

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any review, (B) delegates its authority to review the initial order to one or more persons, unless such delegation is expressly prohibited by law, or (C) authorizes one or more persons to review the initial order, subject to further review by the agency head.

(b) A petition for review of an initial order must be filed with the agency head, or with any person designated for this purpose by rule and regulation of the state agency, within 15 days after service of the initial order. If the agency head on its own motion decides to review an initial order, the agency head shall give written notice of its intention to review the initial order within 15 days after its service. If the agency head determines not to review an initial order in response to a petition for review, the agency head shall, within 20 days after filing of the petition for review, serve on each party an order stating that review will not be exercised.

(c) The petition for review shall state its basis. If the agency head on its own motion gives notice of its intent to review an initial order, the agency head shall identify the issues that it intends to review.

(d) In reviewing an initial order, the agency head or designee shall exercise all the decision-making power that the agency head or designee would have had to render a final order had the agency head or designee presided over the hearing, except to the extent that the issues subject to review are limited by a provision of law or by the agency head or designee upon notice to all parties.

(e) The agency head or designee shall afford each party an opportunity to present briefs and may afford each party an opportunity to present oral argument.

(f) The agency head or designee shall render a final order disposing of the proceeding or remand the matter for further proceedings with instructions to the person who rendered the initial order. Upon remanding a matter, the agency head or designee may order such temporary relief as is authorized and appropriate.

(g) A final order or an order remanding the matter for further proceedings shall be rendered in writing and served within 30 days after receipt of briefs and oral argument unless that period is waived or extended with the written consent of all parties or for good cause shown.

(h) A final order or an order remanding the matter for further proceedings under this sec-

tion shall identify any difference between this order and the initial order and shall include, or incorporate by express reference to the initial order, all the matters required by subsection (c) of K.S.A. 77-526 and amendments thereto.

(i) The agency head shall cause copies of the final order or order remanding the matter for further proceedings to be served on each party in the manner prescribed by K.S.A. 77-531 and amendments thereto.

History: L. 1984, ch. 313, § 27; L. 1988, ch. 356, § 14; July 1, 1989.

**77-528. Stay.** A party may submit to the presiding officer or agency head a petition for stay of effectiveness of an initial or final order until the time at which a petition for judicial review would no longer be timely, unless otherwise provided by statute or stated in the initial or final order. The presiding officer or agency head may take action on the petition for stay, either before or after the effective date of the initial or final order.

History: L. 1984, ch. 313, § 28; July 1, 1985.

**77-528. Reconsideration.** (a) Any party, within 15 days after service of a final order, may file a petition for reconsideration with the agency head, stating the specific grounds upon which relief is requested. The filing of the petition is not a prerequisite for seeking administrative or judicial review except as provided in K.S.A. 44-1010 and 44-1115 and amendments thereto concerning orders of the commission on civil rights, K.S.A. 1987 Supp. 55-606 and 66-118b and amendments thereto concerning orders of the corporation commission and K.S.A. 1987 Supp. 74-2426 and amendments thereto concerning orders of the board of tax appeals.

(b) The agency head shall render a written order denying the petition, granting the petition and dissolving or modifying the final order, or granting the petition and setting the matter for further proceedings. The petition may be granted, in whole or in part, only if the agency head states, in the written order, findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, to justify the order. The petition is deemed to have been denied if the agency head does not dispose of it within 20 days after the filing of the petition.

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An order under this section shall be served on the parties in the manner prescribed by K.S.A. 77-531 and amendments thereto.

History: L. 1984, ch. 313, § 29; L. 1988, ch. 356, § 15; July 1, 1989.

Law Review and Bar Journal References:  
"Appellate Court Jurisdiction: An Update," Debra S. Byrd, 58 J.K.B.A. No. 1, 21, 23 (1989).

**77-530. Orders, when effective.** (a) Unless a later date is stated in a final order or a stay is granted, a final order is effective upon service.

(b) Unless a later date is stated in an initial order or a stay is granted, an initial order shall become effective and shall become the final order: (1) When the initial order is served, if administrative review is unavailable; (2) when the agency head serves an order stating, after a petition for review has been filed, that review will not be exercised; or (3) 30 days after service if no party has filed a petition for review by the agency head, the agency head has not given written notice of its intention to exercise review and review by the agency head is not otherwise required by law.

(c) This section does not preclude a state agency from taking immediate action to protect the public interest in accordance with K.S.A. 77-536 and amendments thereto.

History: L. 1984, ch. 313, § 30; L. 1988, ch. 356, § 16; July 1, 1989.

**77-531. Service of order.** Service of an order or notice shall be made upon the party and the party's attorney of record, if any, by delivering a copy of the order or notice to the person to be served or by mailing a copy of the order or notice to the person at the person's last known address. Delivery of a copy of an order or notice means handing the order or notice to the person or leaving the order or notice at the person's principal place of business or residence with a person of suitable age and discretion who works or resides therein. Service shall be presumed if the presiding officer, or a person directed to make service by the presiding officer, makes a written certificate of service. Service by mail is complete upon mailing. Whenever a party has the right or is required to do some act or take some proceedings within a prescribed period after service of a notice or order and the notice or order is served by mail, three days shall be added to the prescribed period.

History: L. 1984, ch. 313, § 31; July 1, 1985.

**77-532. Record.** (a) A state agency shall maintain an official record of each formal hearing.

(b) The state agency record consists only of:

- (1) Notices of all proceedings;
- (2) any prehearing order;
- (3) any motions, pleadings, briefs, petitions, requests, and intermediate rulings;
- (4) evidence received or considered;
- (5) a statement of matters officially noticed;
- (6) proffers of proof and objections and rulings thereon;
- (7) proposed findings, requested orders and exceptions;
- (8) the record prepared for the presiding officer at the hearing, together with any transcript of all or part of the hearing considered before final disposition of the proceeding;
- (9) any final order, initial order, or order on reconsideration; and
- (10) staff memoranda or data submitted to the presiding officer.

(c) Except to the extent that this act, or another statute provides otherwise, the state agency record, excluding matters under paragraph (10) of subsection (b), constitutes the exclusive basis for state agency action in formal hearings and for judicial review thereof.

History: L. 1984, ch. 313, § 32; L. 1988, ch. 356, § 17; July 1, 1989.

CONFERENCE HEARING

**77-533. Conference hearing; use, when.** A conference hearing may be used if its use in the circumstances does not violate any provision of law and where there is:

- (a) A matter in which there is no disputed issue of material fact; or
- (b) a matter in which there is a disputed issue of material fact and the parties agree to a conference hearing.

History: L. 1984, ch. 313, § 33; L. 1988, ch. 356, § 18; July 1, 1989.

Law Review and Bar Journal References:  
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57, 62 (1985).

**77-534. Procedure.** The procedures of this act pertaining to formal hearings apply to a conference hearing, except to the following extent:

- (a) If a matter is initiated as a conference hearing, no prehearing conference may be held.

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(b) The provisions of K.S.A. 77-522 and amendments thereto do not apply to conference hearings insofar as those provisions authorize the issuance and enforcement of subpoenas and discovery orders, but do apply to conference hearings insofar as those provisions authorize the presiding officer to issue protective orders at the request of any party or upon the presiding officer's motion.

(c) Paragraphs (a), (b) and (c) of K.S.A. 77-523 and amendments thereto do not apply; but (1) the presiding officer shall regulate the course of the proceedings; (2) only the parties may testify and present written exhibits; and (3) the parties may offer comments on the issues.

History: L. 1984, ch. 313, § 34; L. 1988, ch. 356, § 19; July 1, 1989.

**77-535. Disclosure of material or essential facts.** (a) If during a conference hearing the presiding officer has reason to believe that material facts are in dispute, the presiding officer may require any party to state the identity of the witnesses or other sources through whom the party would propose to present proof if the proceeding were converted to a formal hearing, but if disclosure of any fact, allegation or source is privileged or expressly prohibited by any provision of law, the presiding officer may require the party to indicate that confidential facts, allegations or sources are involved, but not to disclose the confidential facts, allegations or sources.

(b) If during a conference hearing a party has reason to believe that essential facts must be obtained in order to permit an adequate presentation of the case, the party may inform the presiding officer regarding the general nature of the facts and the sources from whom the party would propose to obtain those facts if the proceeding were converted to a formal hearing.

History: L. 1984, ch. 313, § 35; L. 1988, ch. 356, § 20; July 1, 1989.

**EMERGENCY PROCEEDINGS**

**77-536. Emergency proceedings; use, when; procedure.** (a) A state agency may use emergency proceedings: (1) In a situation involving an immediate danger to the public health, safety or welfare requiring immediate state agency action or (2) as otherwise provided by law.

(b) The state agency may take only such action as is necessary: (1) To prevent or avoid the immediate danger to the public health,

safety or welfare that justifies use of emergency adjudication or (2) to remedy a situation for which use of emergency adjudication is otherwise provided by law.

(c) The state agency shall render an order, including a brief statement of findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, to justify the state agency's decision to take the specific action and the determination of: (1) An immediate danger or (2) the existence of a situation for which use of emergency adjudication is otherwise provided by law.

(d) The state agency shall give such notice as is practicable to persons who are required to comply with the order. The order is effective when rendered. Notice under this subsection shall constitute service for the purposes of the act for judicial review and civil enforcement of agency actions.

(e) After issuing an order pursuant to this section, the state agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not justify the use of emergency proceedings under subsection (a).

(f) The state agency record consists of any documents regarding the matter that were considered or prepared by the state agency. The state agency shall maintain these documents as its official record.

(g) Unless otherwise required by a provision of law, the state agency record need not constitute the exclusive basis for state agency action in emergency proceedings or for judicial review thereof.

History: L. 1984, ch. 313, § 36; L. 1988, ch. 356, § 21; July 1, 1989.

Law Review and Bar Journal References:  
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.E.A. 53, 57, 65 (1985).

**SUMMARY PROCEEDINGS**

**77-537. Summary proceedings; use, when; right to request hearing; orders, contents.** (a) A state agency may use summary proceedings, subject to a party's request for a hearing on the order, if:

(1) The use of those proceedings in the circumstances does not violate any provision of law; and

(2) the protection of the public interest does not require the state agency to give notice and an opportunity to participate to persons other than the parties.

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(b) The state agency shall serve each party with a copy of the order in a summary proceeding in the manner prescribed by K.S.A. 77-531, and amendments thereto. The order shall include at least:

(1) A statement of the state agency's action and, if unfavorable action is taken, a brief statement of the reasons for the action;

(2) notice of the time and manner for requesting a hearing on the order; and

(3) notice that, if a hearing is not requested, the order shall become effective upon the expiration of the time for requesting a hearing.

History: L. 1984, ch. 313, § 37; L. 1988, ch. 356, § 22; L. 1989, ch. 283, § 6; July 1.

Law Review and Bar Journal References:  
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57, 63 (1985).

**77-538 to 77-540.**

History: L. 1984, ch. 313, §§ 38 to 40; L. 1988, ch. 356, §§ 23 to 25; Repealed, L. 1989, ch. 283, § 26; July 1.

**77-541.** Same; record. (a) The state agency record for a summary proceeding consists of any documents regarding the matter that were considered or prepared by the state agency. The state agency shall maintain these documents as its official record.

(b) Unless otherwise required by a provision of law, the agency record need not constitute the exclusive basis for agency action in summary proceedings or for judicial review thereof.

History: L. 1984, ch. 313, § 41; L. 1988, ch. 356, § 26; L. 1989, ch. 283, § 7; July 1.

**77-542 to 77-544.** Reserved.

**77-545.** State corporation commission; adjudicative proceedings; ex parte communications; file and docket, contents; technical staff, not party to proceedings. (a) This section applies to adjudicative proceedings before the state corporation commission.

(b) (1) After the commission has determined and announced that a hearing should be held, and prior to the issuance of a final order, no parties to the proceeding, or their counsel, shall discuss the merits of the matter or proceeding with the presiding officer unless reasonable notice is given to all parties who have appeared to enable the parties to be present at the conference.

(2) After the commission has determined and announced that a hearing should be held,

prior to the issuance of a final order, copies of any written communications from any party regarding the proceeding that are directed to the presiding officer shall be mailed to all parties of record and proof of service shall be furnished to the commission. Communications requested by members of the commission staff from any party and any written communications received by members of the commission staff from any party shall be made a part of the file and the docket and shall be made available to all persons who desire to use them, provided that all commission requests for information from a party shall be mailed to all parties of record.

(3) The person or persons to whom any ex parte communication has been made shall promptly and fully inform the full commission of the substance of the communication, and the circumstances thereof, to enable the commission to take appropriate action.

(c) For purposes of this section, no member of the technical staff shall be considered a party to any proceeding before the commission, regardless of participation in staff investigations with respect to the proceeding or of participation in the proceeding as a witness. Since the purpose of the staff is to aid the commission in the proper discharge of commission duties, the presiding officers shall be free at all times to confer with any staff member with respect to any proceeding. However, no facts that are outside the record, and that reasonably could be expected to influence the decision in any matter pending before the commission, shall be furnished to any presiding officer unless all parties to the proceeding are likewise informed and afforded a reasonable opportunity to respond. Subsection (b) shall apply to staff counsel in regard to any adjudicatory proceeding before the commission.

(d) All letters and written communications that are received by the presiding officer from members of the general public, and that are in the nature of ex parte communications, shall be made a part of the file in the docket and shall be made available to all persons who desire to see them. The deposit of such written communications and letters in the file shall not make them a part of the official record of the case.

History: L. 1988, ch. 356, § 355; July 1, 1989.

**77-546.** Commissioner of insurance; adjudicative proceedings; ex parte communications; file and docket, contents; technical staff.

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not party to proceedings. (a) This section applies to adjudicative proceedings before the commissioner of insurance concerning any rate, or any rule, regulation or practice pertaining to the rates over which the commissioner has jurisdiction and adjudicative proceedings held pursuant to the Kansas insurance holding companies act.

(b) (1) After the commissioner has determined and announced that a hearing should be held, and prior to the issuance of a final order, no parties to the proceeding, or their counsel, shall discuss the merits of the matter or proceeding with the presiding officer unless reasonable notice is given to all parties who have appeared to enable the parties to be present at the conference.

(2) After the commissioner has determined and announced that a hearing should be held, prior to the issuance of a final order, copies of any written communications from any party regarding the proceeding that are directed to the presiding officer shall be mailed to all parties of record and proof of service shall be furnished to the commissioner. Communications requested by the commissioner's staff from any party and any written communication received by the commissioner's staff from any party shall be made a part of the file and the docket and shall be made available to all persons who desire to use them, provided that the commissioner's requests for information from a party shall be mailed to all parties of record.

(3) The person or persons to whom any *ex parte* communication has been made shall promptly and fully inform the commissioner of the substance of the communication, and the circumstances thereof, to enable the commissioner to take appropriate action.

(c) For purposes of this section, no member of the commissioner's technical staff shall be considered a party to any proceeding before the commissioner, regardless of participation in staff investigations with respect to the proceeding or of participation in the proceeding as a witness. Since the purpose of the staff is to aid the commissioner in the proper discharge of the commissioner's duties, the presiding officer shall be free at all times to confer with any staff member with respect to any proceeding. However, no facts that are outside the record, and that reasonably could be expected to influence the decision in any matter pending before the commissioner, shall be furnished to any presiding officer unless all parties to the proceeding are likewise informed and

afforded a reasonable opportunity to respond. Subsection (b) shall apply to staff counsel who have participated in the proceeding in regard to any adjudicatory proceeding before the commissioner.

(d) All letters and written communications that are received by the presiding officer from members of the general public, and that are in the nature of *ex parte* communications, shall be made a part of the file in the docket and shall be made available to all persons who desire to see them. The deposit of such written communications and letters in the file shall not make them a part of the official record of the case.

History: L. 1988, ch. 356, § 356; July 1, 1989.

**77-547.** Same; administrative proceedings; agency head, defined. For purposes of administrative proceedings of the insurance department under the Kansas administrative procedure act, "agency head" means the commissioner of insurance or the assistant commissioner of insurance, when acting on behalf of the commissioner.

History: L. 1988, ch. 356, § 358; July 1, 1989.

**77-548.** Director of taxation; adjudicative proceedings; *ex parte* communications; file and docket, contents; technical staff, not party to proceedings. (a) This section applies to adjudicative proceedings before the director of taxation.

(b) (1) After the director has determined and announced that a hearing should be held, and prior to the issuance of a final order, no parties to the proceeding, or their counsel, shall discuss the merits of the matter or proceeding with the presiding officer unless reasonable notice is given to all parties who have appeared to enable the parties to be present at the conference.

(2) After the director has determined and announced that a hearing should be held, prior to the issuance of a final order, copies of any written communications from any party regarding the proceeding that are directed to the presiding officer shall be mailed to all parties of record and proof of service shall be furnished to the director. Communications requested by the director's staff from any party and any written communication received by the director's staff from any party shall be made a part of the file and the docket and shall be made available to all persons who desire to use them.

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provided that the director's requests for information from a party shall be mailed to all parties of record.

(3) The person or persons to whom any *ex parte* communication has been made shall promptly and fully inform the director of the substance of the communication, and the circumstances thereof, to enable the director of any division within the department to take appropriate action.

(c) For purposes of this section, no member of the director's technical staff shall be considered a party to any proceeding before the director, regardless of participation in staff investigations with respect to the proceeding or of participation in the proceeding as a witness. Since the purpose of the staff is to aid the director in the proper discharge of the director's duties, the presiding officer shall be free at all times to confer with any staff member with respect to any proceeding. However, no facts that are outside the record, and that reasonably could be expected to influence the decision in any matter pending before the director, shall be furnished to any presiding officer unless all parties to the proceeding are likewise informed and afforded a reasonable opportunity to respond. Subsection (b) shall apply to staff counsel who have participated in the proceeding in regard to any adjudicatory proceeding before the director.

(d) All letters and written communications that are received by the presiding officer from members of the general public, and that are in the nature of *ex parte* communications, shall be made a part of the file in the docket and shall be made available to all persons who desire to see them. The deposit of such written communications and letters in the file shall not make them a part of the official record of the case.

History: L. 1988, ch. 356, § 357; July 1, 1989.

**77-548.** Same; application for an order; when proceedings required; agency head defined; final orders. (a) The filing of a return with the director of taxation under article 15, 32, 33, 34, 36, 37, 41 or 47 of chapter 79 of the Kansas Statutes Annotated, and amendments thereto, shall not be deemed an application for an order under the Kansas administrative procedure act.

(b) A determination by the division of taxation or the audit services bureau of the department of revenue concerning tax liability

under article 15, 32, 33, 34, 36, 37, 41 or 47 of chapter 79 of the Kansas Statutes Annotated, and amendments thereto, which is made prior to the opportunity for a hearing before the director of taxation on such tax liability, shall not require an adjudicative proceeding under the Kansas administrative procedure act.

(c) For purposes of the Kansas administrative procedure act, the director of taxation shall be deemed the agency head in regard to orders rendered by the director under chapter 79 of the Kansas Statutes Annotated, and amendments thereto.

(d) Final orders of the director of taxation pursuant to K.S.A. 77-526 and amendments thereto, shall be rendered in writing and served within 120 days after conclusion of the hearing or after submission of proposed findings in accordance with subsection (f) of K.S.A. 77-526 and amendments thereto, unless this period is waived or extended with the written consent of all parties or for good cause shown.

History: L. 1988, ch. 356, § 359; July 1, 1989.

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Law Review and Bar Journal References:

"Administrative Law: The Creation of a Presumption of Unreviewability in Cases of Administrative Inaction (Heckler v. Chaney, 105 S.Ct. 1649 (1985))." Warren F. Frost, 25 W.L.J. 347, 348 (1986).

"The New Kansas Administrative Procedure and Judicial Review Acts." David L. Ryan, 34 J.K.B.A. 53, 55 (1985).

"Medicaid and Long-Term Institutional Care for the Victims of Catastrophic Disabling Illness." Patrick H. Donahue, 36 J.K.B.A. No. 8, 26, 35 (1987).

"Transportation in Transition: KCC Regulation of Motor Carriers into the 1980's." Mary Piper Wattig, 37(5) J.K.B.A. 19, 34 (1988).

"Reappraisal—How Long Will It Last?" Bruce Landock, 38 J.K.B.A. No. 1, 15, 18 (1989).

Attorney General's Opinions:

Parimutuel racing, refund of deposit of unsuccessful applicant for license; setoffs. 88-120.

CASE ANNOTATIONS

1. Cited, party aggrieved by administrative ruling not free to pick and choose procedure in district court action to avoid administrative remedies. State ex rel. Smith v. Miller, 239 K. 187, 190, 718 P.2d 1298 (1986).

2. Venue of appeal to district court from decision of SRS committee is the county where original application for benefits was filed. Midfield v. State, 11 K.A.2d 617, 618, 619, 620, 621, 731 P.2d 854 (1987).

3. Judicial review unavailable where party fails to exhaust administrative remedies as required by 77-607 and 77-612. W.S. Dickey Clay Mfg. Co. v. Kansas Corp Comm'n, 241 K. 744, 751, 740 P.2d 585 (1987).

4. Cited, prohibitions against deductions from employee's wages except as permitted by 44-319 examined. Excel

V# MS-91-14

Approval Date JUN 12 1991

Effective Date JAN - 1 1991

Superseded MS-90-46

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30-7-64

30-7-64. Definitions. (a) "Appellant" means an individual or entity that has requested a fair hearing from an agency decision affecting the individual or entity.

(b) "Applicant" means an individual who has applied for or requested assistance or benefits from a program administered by the agency.

(c) "Recipient" means an individual who is receiving assistance or benefits from a program administered by the agency. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-65. Notice to recipients of intended action. (a) (1) "Adequate" means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific policies supporting the action, explanation of the individual's right to request a fair hearing, and the circumstances under which assistance is continued if a hearing is requested.

(2) "Timely" means that the notice shall be mailed at least 10 days before the date upon which the action would become effective.

(b) In cases of intended action to discontinue, terminate, suspend or reduce assistance, the agency shall give timely and adequate notice, except as set forth in section (c) of this regulation.

(c) The agency may dispense with timely notice but shall send adequate notice not later than the date of action when:

(1) The agency has factual information confirming the death of a recipient or of the ADC payee when there is no relative available to serve as new payee;

(2) the agency receives a clear written statement signed by a recipient that the recipient no longer wishes assistance or that gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, an understanding that termination or reduction of assistance shall be the consequence of supplying the information;

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Page 3

30-7-65 (2)

the recipient has been admitted or committed to an institution, and further payments to that individual are not required by program regulations as long as the person resides in that institution;

the recipient has been placed in skilled nursing care, intermediate care or long-term hospitalization;

the recipient's whereabouts are unknown and agency mail sent to the recipient has been returned by the post office indicating no known forwarding address. The check shall, however, be made available to the recipient if the recipient's whereabouts become known during the payment period covered by a check;

the recipient has been accepted for assistance in a new institution and that fact has been established by the agency;

a child is removed from the home as a result of a judicial proceeding, or voluntarily placed in foster care by the legal guardian;

a change in level of medical care is prescribed by the attending physician;

a special allowance granted for a specific period is about to expire and the recipient has been informed in writing at the time of initiation that the allowance shall automatically terminate at the end of the specified period; or

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30-7-65 (3)

(10) the agency takes action because of information the recipient furnished in a monthly status report or because the recipient has failed to submit a complete or a timely monthly status report without good cause. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-66 (1)

30-7-66. Continuation of assistance. (a) If the recipient requests a hearing within the timely notice period as required by K.A.R. 30-7-65, assistance shall not be suspended, reduced, discontinued, or terminated, (but is subject to recovery by the agency if its action is sustained), until an initial decision of the hearing officer is rendered in the matter, unless:

(1) The request for fair hearing concerns the suspension of program payments to a provider or the termination of a provider from program participation;

(2) the request for a fair hearing concerns a discontinued program or service;

(3) a determination is made by the hearing officer that the sole issue is one of federal or state law, regulation or policy, or change in federal or state law, regulation or policy and not one of incorrect grant computation; or

(4) a change affecting the recipient's assistance occurs while the hearing decision is pending and the recipient fails to request a hearing after notice of the change.

(b) The agency shall promptly inform the recipient in writing if assistance is to be discontinued pending the hearing decision.

(c) In any case where action was taken without timely notice, if the recipient requests a hearing within 10 days of the mailing of the notice of the action, and the agency determines that the action resulted from other than the application of federal or

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30-7-66 (2)

state law or policy or a change in federal or state law, assistance shall be reinstated and continued until a decision is rendered in the matter except as set forth in (a)(1), (2), (3), or (4). The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-67

30-7-67. Administrative hearings section, hearing officer. The administrative hearings section shall administer the agency's fair hearing program. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-68

30-7-68. Request for fair hearing. (a) Unless preempted by federal law, a request for fair hearing shall be in writing and received by the agency within 30 days from the date the order or notice of action is mailed. Pursuant to K.S.A. 1988 Supp. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(b) A request for fair hearing involving food stamps shall be received by the agency within 90 days from the date the notice of action is mailed. Pursuant to K.S.A. 1988 Supp. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(c) The freedom to request a fair hearing shall not be limited or interfered with by the agency. The effective date of this regulation shall be January 1, 1990. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1989, Ch. 283, Sec. 21; effective July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990.)

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30-7-68

30-7-68. Request for fair hearing. (a) Unless preempted by federal law, a request for fair hearing shall be in writing and received by the agency within 30 days from the date of the order or notice of action. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(b) A request for fair hearing involving food stamps shall be received by the agency within 90 days from the date of the notice of action. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(c) The freedom to request a fair hearing shall not be limited or interfered with by the agency. The effective date of this regulation shall be January 2, 1991. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended Jan. 7, 1991.)

TN# MS-91-14

Approval Date

JUN 12 1991

Effective Date

JAN - 1 1991

Superseded MS-90-46

KANSAS MEDICAID STATE PLAN

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30-7-69

30-7-69. Pre-appeal administrative remedies. (a) A pre-appeal administrative remedy is any procedure or process, the purpose of which is to encourage settlement or otherwise resolve the dispute before appeal to the administrative hearings section.

(b) Pre-appeal administrative remedies are to be encouraged to promote the resolution of disputes between the parties involved. Pre-appeal administrative remedies may also be used by the parties to narrow and define the issues to be appealed to the administrative hearings section. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-70

30-7-70. Agency's review of decision. (a) Upon receipt of notice that a request for fair hearing has been made, the agency shall review its action or decision. Upon reconsideration, the agency may amend or change its action or decision before or during the hearing.

(b) If a satisfactory adjustment is reached prior to the hearing, the agency shall submit a report to the hearing officer, in writing, but the appeal shall remain pending until the appellant submits a signed, written statement withdrawing the appellant's request for fair hearing. If the appellant fails to timely submit a signed, written statement withdrawing the request for fair hearing, the hearing officer may dismiss the request for fair hearing. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-71

30-7-71. Venue. (a) Fair hearings for applicants or recipients shall be held in the social and rehabilitation services' administrative area in which the applicant or recipient resides unless another site has been designated by the hearing officer or the hearing is conducted pursuant to the provisions of K.A.R. 30-7-72.

(b) Fair hearings for other appellants shall be held in Topeka, Kansas unless another site has been designated by the hearing officer or the hearing is conducted pursuant to the provisions of K.A.R. 30-7-72. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

.N# MS-91-14

Approval Date JUN 12 1991 Effective Date JAN - 1 1991 Superseded MS-90-46

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30-7-72

30-7-72. Telephone hearings. The hearing officer may conduct the fair hearing or any prehearing by telephone or other electronic means if each participant in the hearing or prehearing has an opportunity to participate in the entire proceeding while the proceeding is taking place. A party may be granted a face to face hearing or prehearing if good cause can be shown that a fair and impartial hearing or prehearing could not be conducted by telephone or other electronic means. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-73

30-7-73. Summary reversals. The hearing officer may, without notice or hearing, summarily reverse the agency's decision or action in the matter if it is clear from the agency's summary that the agency's decision or action was incorrect. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-74

30-7-74. Independent medical, psychiatric and psychological examinations. When the hearing involves medical, psychiatric or psychological issues, the hearing officer may order on the hearing officer's own motion that an independent medical, psychiatric or psychological assessment other than that of the person or persons involved in making the original decision shall be obtained at agency expense and made part of the record if the hearing officer considers it necessary. If a party requests the independent assessment, that party shall pay the costs incurred in obtaining the assessment. If the party requesting the assessment signs a poverty affidavit, the independent medical, psychiatric or psychological assessment shall be performed at agency expense. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-75

30-7-75. Agency's summary. Within seven days after notification of the request for fair hearing the agency shall furnish the appellant and the administrative hearings section with a summary setting forth the following information:

(a) Name and address of the appellant;

(b) a summary statement concerning why the appellant is filing a request for a fair hearing;

(c) a brief chronological summary of the agency's action in relationship to the appellant's request for a fair hearing;

(d) a statement of the basis of the agency's decision;

(e) a citation of the applicable policies relied upon by the agency;

(f) a copy of the notice which notified appellant of the decision in question;

(g) applicable correspondence; and

(h) the name and title of the person or persons who will represent the agency at the hearing. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-76

30-7-76. Transcripts. (a) A transcript of the hearing may be prepared if requested by an appellant, the agency, the hearing officer, the state appeals committee or the secretary. The party requesting the transcript shall pay any costs associated in obtaining a transcript.

(b) If an appellant requests a transcript, the agency shall pay the costs of transcribing the recording if the appellant signs a poverty affidavit.

(c) If a transcript is prepared, the reporter shall sign the following certification on all copies: "This is to certify that \_\_\_\_\_ conducted a hearing on the application of \_\_\_\_\_ in \_\_\_\_\_ county, state of Kansas, on \_\_\_\_\_ at \_\_\_\_\_ and that the foregoing is a true and correct transcript of the record of the hearing."

\_\_\_\_\_  
Signature of Reporter

The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

KANSAS MEDICAID STATE PLAN

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30-7-77

30-7-77. Rehearing. (a) Any party, within 15 days after service of the hearing officer's decision, may file a petition for rehearing with the administrative hearings section, stating the specific grounds upon which the rehearing of the hearing officer's decision is requested.

(b) A rehearing may be granted to either party on all or part of the issues when it appears that the rights of the party are substantially affected because of:

(1) An erroneous ruling of the hearing officer;

(2) the decision in whole or in part is contrary to the evidence; or

(3) newly discovered evidence which the moving party could not with reasonable diligence have discovered or produced at the hearing.

(c) The filing of a petition for rehearing is not a prerequisite for review at any stage of the proceedings. The filing of a petition for review does not stay any time limits or further proceedings that may be conducted under the Kansas administrative procedures act, K.S.A. 77-501 et seq. and amendments thereto, or any other provision of law. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

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30-7-78

30-7-78. State appeals committee. (a) The secretary may appoint one or more state appeals committees to hear appeals from the decisions or orders of the hearing officers.

(b) The committees shall consist of three impartial persons.

(c) Decisions of the committee shall be by majority vote. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

06/16/98

Kansas Medicaid Plan

Attachment 4.19 D  
Part II  
Subpart CC  
p.1 of 1

Public process for proposed changes in ICF/MR payment rates or payment methodologies. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.



KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

November 13, 1996

Mr. Richard P. Brummel
Associate Regional Administrator for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, MO 64106

95 NOV 19 PM 12:37
KANSAS MEDICAID
REVISION VII

Dear Mr. Brummel:

I am writing in reference to your response to Kansas Medicaid State Plan Amendment MS-96-06, incorporating Kansas regulation changes effective April 17, 1996 into Attachment 4.19D. Please note, pursuant to comments in your response, a revision of Amendment MS-96-06 is attached.

ASSURANCES

In accordance with 42 CFR 447.253 and 42 CFR 447.272, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) services. The assurances your office requested are furnished herewith and the agency complies with all other requirements.

42 CFR 447.253(b)(1)(i) Reasonable and Adequate Payment Rates

The State of Kansas continues to pay ICFs/MR for services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide the services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(2) Upper Payment Limits

The State of Kansas assures that the estimated average proposed Medicaid payment rate is reasonably expected to pay no more in the aggregate for ICF/MR services than the amount that the agency reasonably estimates would be paid under the Medicare principles of reimbursement.

Refers to MS-96-06

State Plan TN# 96-06 Effective Date APR 17 1996
Supersedes TN# Approval Date DEC 20 1996

Mr. Richard P. Brummel  
November 13, 1996  
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#### 42 CFR 447.272(a) & (b) Upper Payment Limits

The State of Kansas assures that the estimated average proposed Medicaid payment rate is reasonably expected to pay no more in the aggregate for state and ~~private~~ ICF/MR services than the amount that the agency reasonably estimates would be paid under the Medicare principles of reimbursement.

#### 42 CFR 447.253(d) Reevaluation of Assets

The State of Kansas assures that for changes in ownership of any ICF/MR after October 1, 1985, methods and standards employed in the valuation of capital assets for purposes of determining payment rates will not increase the value of those assets by more than the lesser of one-half of the percentage increase in either the Dodge construction index, or the Consumer Price Index for All Urban Consumers, applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

#### 42 CFR 447.253(e) Provider Appeals

The State of Kansas, in accordance with federal regulations and with the Kansas Administrative Regulations, provides a fair hearing, appeal, or exception procedure that allows for an administrative review and an appeal by the provider as to its payment rates.

#### 42 CFR 447.253(f) Uniform Cost Reports

ICF/MR providers are required to file annual cost reports in accordance with Kansas Administrative Regulations and Attachment 4.19D, Part II, Subpart O.

#### 42 CFR 447.253(g) Audit Requirements

The State of Kansas performs a desk review on all cost reports within six (6) months after receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

#### 42 CFR 447.253(h) Public Notice

In accordance with 42 CFR 447.205, public notice is given for the significant changes proposed to the methods and standards for setting ICF/MR payment rates.

#### 42 CFR 447.253(i) Rates Paid

The rates paid through the State of Kansas have been determined in accordance with methods and standards specified in an approved Medicaid State Plan.

Refers to MS-96-06

State Plan TWA 96-06 Effective Date APR 17 1996  
Supersedes TWA \_\_\_\_\_ Approval Date DEC 20 1996

\* pen ink per  
mmalcolm 12/12/96

Mr. Richard P. Brummel  
November 13, 1996  
Page 3

#### 42 CFR 447.255 Related Information

Estimated Average Rate 04/17/96	\$155.98
Estimated Average Rate 04/17/95	\$151.56
Per Diem Increase	\$ 4.42
Average Percent Increase	2.9%

Both the short-term and the long-term effects of these rate changes are estimated to:

1. Maintain the availability of services on a statewide and geographic area basis.

There are approximately 44 licensed ICFs/MR in the State of Kansas. One hundred percent are also certified to participate in the Medicaid Program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies;

2. Maintain the type of care furnished; and,
3. Maintain the extent of provider participation.

The extent of provider participation should not be affected by this change. One hundred percent of the available providers are already participating in the program.

#### EXPLANATIONS

Amendment MS-96-06, as rewritten, does not violate Section 1902(a)(10)(B)(i) of the Social Security Act.

The State of Kansas submits the following *rewriting* of Amendment MS-96-06 (Section 30-10-218(3)(c)) to ensure compliance with the comparability standards set forth in Section 1902(a)(10)(B)(1) of the Social Security Act :

- (c) ICFs/MR shall not be reimbursed for services provided to individuals admitted on or after the effective date of this regulation unless:
- (1) the community developmental disability organization (CDDO) assigned by the agency first determines such persons meet eligibility requirements established by the agency and the ICF/MR placement is consistent with the preferred lifestyle of the person as specified by the person or the person's guardian, if one has been appointed; or,
  - (2) the admission has been otherwise approved by the agency Commissioner of Mental Health and Developmental Disabilities.

Refers to MS-96-06

State Plan TN# 96-06 Effective Date APR 17 1996  
Supersedes TN# \_\_\_\_\_ Approval Date DEC 20 1996

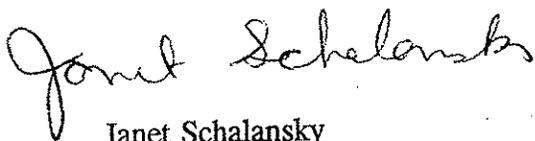
Mr. Richard P. Brummel  
November 13, 1996  
Page 4

According to Amendment MS-96-06, as rewritten, an individual whose preferred lifestyle plan indicates a preference for home and community based services may, at the discretion of the Commissioner of Mental Health & Developmental Disabilities, enter an ICF/MR while waiting for those services.

Pursuant to Amendment MS-96-06, as rewritten, an individual who prefers community based services would not enter an ICF/MR while waiting for such services, absent approval by the Commissioner of Mental Health & Developmental Disabilities. Any ICF/MR admitting a person with a preference for community-based services would not be reimbursed for providing those ICF/MR services, absent Commissioner approval, as indicated in the proposed amendment. Under current circumstances, individuals desiring home and community based services would be served in community settings with HCBS/MR waiver funding - without experiencing a wait. Thus, there are great disincentives for ICF/MR placements for those people with a preference for waiver services. At the same time, the rewritten Amendment provides no legal action to those with HCBS preferences who enter an ICF/MR.

Any questions regarding this plan submission should be directed to Marti Malcolm at (913)296-4753.

Sincerely,



Janet Schalansky  
Deputy Secretary

JS:kmm

Attachment

Refers to MS-96-06

State Plan TN# 96-06 Effective Date APR 17 1996  
Supersedes TN# \_\_\_\_\_ Approval Date DEC 20 1996

KS Book 4

Definition of Claims

The state has chosen to define a claim as "all services for one recipient within a bill" for all classes of providers with the exception of adult care homes and pharmacies. For those two classes of providers, a claim is defined as "a line item of service".

State Plan  
Trans. No. MS-79-3  
Submitted 11-1-79  
Approved 12-14-79

KANSAS MEDICAID STATE PLAN

Revisions: HCFA-PM-87-9 (BERC)  
August 1987

Attachment 4.22-A  
Page 1  
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: KANSAS

Requirements for Third Party Liability -  
Identifying Liable Resources

- (b) (1) Data exchanges pursuant to 42 CFR 433.138 (d)(1), (d)(3) and (d)(4) and (e) are conducted periodically as described below.

The Deficit Reductions Act of 1984 (DEFRA) required states to match Medicaid eligible individuals against the files of several agencies. Therefore, State Income and Eligibility Verification System was initiated. This is an unduplicated match of Medicaid-eligible individuals utilizing social security number and date of birth. The Kansas Department of Social and Rehabilitation Services matches its Medicaid-eligible file against the employment security cross-match, Bendex and the IRS unearned income files. This data is then utilized to meet 42 CFR 433.138 (g)(1)(i) by furnishing monthly printouts to field staff to investigate, to resolve 80 percent of all matches, to document in the case file, and to update the TPR data base within 30 calendar days of receipt. Pursuant to 42 CFR 433.138 (g)(2)(i), information about third party resources is also obtained during the application for eligibility and the redetermination processes. Information is loaded into the KMMIS TPR data base within 30 days by field staff. Data matches are also performed monthly with Workers' Compensation files and routinely and timely with the Kansas Department of Revenue's Drivers' License Accident file. Any new TPR information is loaded into the data base within 60 days by the fiscal agent staff.

Pursuant to 42 CFR 433.138 (d)(4)(ii), a state motor vehicle accident report file data exchange is presently being performed routinely and timely.

Pursuant to 42 CFR 433 (e), diagnosis and trauma code edits are performed on codes 800 through 999, excepting 994.6 (per federal direction). During the weekly claims processing cycle, claims are identified relating to these diagnoses. For single claims in an amount of \$1,000.00, or more or for a \$1,000.00 accumulation of smaller amounts for multiple trauma diagnoses of 800 through 999, a questionnaire is mailed to the recipient. SRS then pursues TPR recovery through its legal staff to recover funds. Information discovered during this process is added to the TPR file if it is not already present. This process takes place within 60 days.

TN/MS-90-41 Approval Date 12/27/90 Effective Date 10/1/90 Supersedes TN/MS-87-41

Associate with 422B:

Mr. Thomas W. Lentz  
Page Two  
July 5, 1990

No deductible, however they do have  
co-pay 20/80 split

3

4. Our process for post payment recovery of pharmacy claims is to monthly have the system search the recipient third liability file for recipients with pharmacy coverage. Claims history is reviewed for these recipients and paid pharmacy claims over \$5.00 that were paid within the last month generate automatically a post-pay bill. At the time post-pay bills are produced, an accounts receivable record is established in the system and the claims are mailed monthly to the applicable insurance carriers as a request for payment up to the extent Medicaid has made payment. All replies (payments, denial, requests for more information) to these billings are delivered to the TPL Accounts Receivable clerk. The clerk determines the correct disposition action to the responses received and reconciles the accounts receivable or provides additional information to the insurance carrier.

*Handwritten notes:*  
No more  
to be  
mail monthly

SUPPLEMENT TO ATTACHMENT 4.22-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:     Kansas    

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE  
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

Revision: HCFA-PM-87-9  
FEBRUARY 1990

ATTACHMENT 4.22-B  
Page 1  
OMB NO.: 0938-0193  
✓ Replacement Page 12-26-90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: KANSAS

Requirements for Third Party Liability-  
Payment of Claims

The threshold amount used in determining whether to seek reimbursement from a liable third party health insurer is \$5.00. No accumulation is performed.

The threshold amount used for trauma-related cases from the fiscal agent (in relation to diagnosis codes 800 - 999 except for code 944.6) is presently \$1,000.00. Accumulation is performed on all claim types.

This threshold was determined by a study performed by the State. From a population of 1243 casualty cases closed in FY 89, a sample of 243 cases (19.5%) were reviewed. Of those cases reviewed, 116 had total medical expenditures between \$500 and \$1000. Of these 116 cases, 112 had no recovery and the other 4 cases had a recovery amount totalling \$2,286.56. The agency estimates that the cost per case for the 116 cases was \$86.56. Multiplying the 116 cases times the cost per case of \$86.56, and subtracting the recovery amount of \$2,286.56, and then dividing that result by the 116 cases indicates that it costs \$66.85 more than is recovered on the average to process cases between \$500 and \$1000.

Providers are not required to bill liable third parties when services covered under the Plan are furnished to an individual on whose behalf child support enforcement is being carried out by the Kansas Department of Social and Rehabilitation Services. A mechanism has been devised to eliminate printing of TPL information on the medical identification card, but automatically post pay bills all services rendered to IV-D children in accordance with their TPL coverage.

TN No. MS-90-41 Approval Date 12/27/90 Effective Date 10/1/90 Supersedes TN No. MS-87-41

HCFA ID:1076P/0019P

Revision: HCFA-PM-91-8 (MB)  
October 1991

ATTACHMENT 4.22-C  
Page 1  
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans
	Not Applicable

TN No. MS-91-47  
Supersedes Nothing  
Approval Date FEB 19 1992  
Effective Date 10/01/91  
HCFA ID: 7985E

# KANSAS MEDICAID STATE PLAN

Attachment 4.24  
Part I  
List of Contents

## Standards for Payments for Nursing Facilities

### List of Contents

#### Part I

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Exhibit A-2	30-10-1c	Provider Agreement
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Exhibit A-5	30-10-2	Standards for Participation
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Exhibit A-7	30-10-7	Screening, Evaluation and Referral for Nursing Facilities
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30-10-1b. Nursing facility program providers. (a) The nursing facility program providers shall include the following types of care facilities:

(1) Nursing facilities; and

(2) nursing facilities for mental health, which shall have been operating in accordance with a provider agreement with the agency on June 30, 1994.

(b) Each provider shall meet the following requirements with regard to any change in the structure of the business entities involved in the ownership, operation, or management of the nursing facility:

(1) The current provider or prospective provider shall notify the agency in writing by certified mail of a proposed change of providers at least 60 days in advance of the closing transaction date. If the current or prospective provider fails to submit a timely notification, the new provider shall assume responsibility for any overpayment made to the previous provider before the transfer. Failure to submit timely notification shall not release the previous provider from responsibility for the overpayment.

(2) Before the dissolution of the provider business entity or a transaction involving a change of ownership of the nursing facility or the change of lessee of the nursing facility, the provider shall notify the agency in writing at least 60 days before the change. If the provider fails to submit a timely notification, the new provider shall assume responsibility for any overpayment made to the previous provider before the

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transfer. Failure to submit timely notification shall not release the previous provider from responsibility for the overpayment. Other overpayment recovery terms may be expressly agreed to in writing by the secretary.

(3) The provider shall submit an application to be a provider of services to the agency for any addition or substitution to a partnership or any change of provider resulting in a completely new partnership. An application shall not be required when a partnership is dissolved and at least one member of the partnership remains as the provider of services.

(4) If a sole proprietor that is not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. The new owner shall submit an application to be a provider of services to the agency.

(5) Each consolidation of two or more unrelated corporations that creates a new corporate entity through an arm's-length transaction shall constitute a change of provider. The new corporate entity resulting from the consolidation shall submit an application to be a provider of services to the agency.

(6) Each change or creation of a new lessee acting as a provider of services shall constitute a change of provider. The new lessee shall submit an application to be a provider of services to the agency.

(7) Each provider shall submit documentation of any other change in the ownership or corporate structure of the business

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entities involved in the ownership, operation, or management of the nursing facility.

(c) Only a change in or creation of a provider of service through a bona fide transaction shall be recognized as resulting in a new provider. The following situations shall not be recognized as resulting in a change of provider, and the facility shall be treated as an ongoing entity:

- (1) A transfer of participating provider corporate stock;
- (2) a merger of one or more corporations with the participating provider corporation surviving;
- (3) the purchase of the facility by the lessee;
- (4) the change or creation of a sublessee acting as the provider of services;
- (5) the creation of a new lessee that is related to the old owner of the facility;
- (6) the creation of a new lessee acting as the provider of services that is related to the old lessee;
- (7) the change or creation of a management firm acting as the provider of services ; and
- (8) the takeover of the lessee's operations by an owner of the facility.

(d) Each new provider shall be subject to a certification survey by the state licensing agency. If certified, the period of certification shall be established by the state licensing agency.

(e) This regulation shall be effective on and after May 1,

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2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended May 1, 2005.)

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30-10-1c

30-10-1c. Provider agreement. (a) As a prerequisite for participation in the medicaid/medikan program as a nursing facility provider, the owner of the real and personal property used to provide the nursing facility services or the lessee of such real and personal property shall enter into a provider agreement with the agency on forms prescribed by the secretary.

(b) Only parties signing a provider agreement shall have rights to enforcement of the agreement. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1982; amended May 1, 1986; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994.)

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30-10-1d. Inadequate care. (a) If the agency determines that inadequate care is being provided to a recipient or that a recipient's rights are being violated, payment to the nursing facility may be terminated or suspended.

(b) If the agency determines that a nursing facility has not corrected deficiencies that significantly and adversely affect the health, safety, nutrition, or sanitation of the nursing facility residents, payments for new admissions shall be denied and future payments for all recipients shall be withheld until the agency determines that the deficiencies have been corrected.

(c) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended, T-87-43, Dec. 19, 1986; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Jan. 3, 1994; amended May 1, 2005.)

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30-10-1f(1)

30-10-1f. Private pay wings. As a prerequisite for participation in the medicaid/medikan program, a nursing facility shall not develop private pay wings or segregate medicaid/medikan residents to separate areas of the nursing facility. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991.)

DEC 03 1994

TN#MS-94-18 Approval Date \_\_\_\_\_ Effective Date 07/01/94 Supersedes TN#MS-94-03

30-10-2. Standards for participation; nursing facilities and nursing facilities for mental health. (a) As a prerequisite for participation in the Kansas medical assistance program as a provider of nursing facility services, each nursing facility and each nursing facility for mental health shall perform the following:

- (1) Provide nursing services;
- (2) meet the requirements of title IV, subtitle C, part 2 of the federal omnibus budget reconciliation act of 1987, effective October 1, 1990, which is adopted by reference;
- (3) be certified for participation in the program for all licensed beds by the Kansas department of health and environment or the federal department of health and human services;
- (4) have been operating under a provider agreement with the agency on June 30, 1994 if the certification is for a nursing facility for mental health;
- (5) submit an application for participation in the program on forms prescribed by the secretary of social and rehabilitation services;
- (6) update provided information as required by the application forms;
- (7) furnish and allow inspection of any information that the agency, its designee, or the United States department of health and

human services may request in order to assure proper payment by the Kansas medical assistance program;

(8) inform all new residents of the availability of a potential eligibility assessment under the federal spousal impoverishment law. This assessment shall be completed by the agency or a local agency office;

(9) ensure that before a nonemergency admission of each resident, state-mandated preadmission and referral services have been completed by the Kansas department on aging;

(10) provide nonemergency transportation; and

(11) submit to the agency a copy of the resident assessment form for each resident as follows:

(A) Each nursing facility shall complete a resident assessment form no later than 14 days after admission, no later than 14 days after a significant change in the resident's physical or mental condition, and in no case less often than once every 12 months. Each nursing facility shall conduct a review by completing the resident assessment form no less often than once every three months. Assessments shall be used to monitor the appropriate level of care.

(B) Each nursing facility shall submit resident assessment forms, including the tracking documents, within seven days of completion. Each resident assessment form shall be sent to the

state data base by electronic transmission. A resident assessment form shall be considered timely submitted upon the receipt of the electronic submission.

(C) Penalty for nonsubmission of accurate and timely assessment. If 10 percent or more of a nursing facility's assessments are not completed and submitted as required, all further payments to the provider shall be suspended until the forms have been completed and submitted electronically. Thirty days before suspending payment to a provider, written notice stating the agency's intent to suspend payments shall be sent by the agency to the provider. This notice shall explain the basis for the agency's determination and shall explain the necessary corrective action that must be taken before payments are reinstated.

(D) Any assessment that cannot be classified shall be assigned to the lowest classification group.

(b) This regulation shall be effective on and after May 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-43, Aug. 16, 1974; effective, E-74-63, Dec. 4, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1982; amended May 1, 1983; amended May 1, 1985;

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amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990;  
amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended  
Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended  
Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended  
July 1, 1998; amended Jan. 1, 1999; amended May 1, 2002)

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30-10-6. Admission procedure. (a) The physical, emotional, social, and cognitive status of each individual, including any individual from out of state, who is seeking admission to a nursing facility or a nursing facility for mental health providing care under title XIX of the federal social security act shall be assessed to determine the need for care and the appropriateness of services in accordance with K.S.A. 39-968 and amendments thereto.

(b) Nursing facility services and nursing facility for mental health services shall be provided pursuant to title IV, subtitle C, part 2, pp. 190-230, of the federal omnibus budget reconciliation act of 1987, effective October 1, 1990, which is adopted by reference in K.A.R. 30-10-2. Each resident shall receive a comprehensive medical evaluation and an explicit recommendation by the physician concerning the level of care needed.

(c) A nursing facility shall not require a private-paying resident to remain in a private-pay status for any period of time after the resident becomes eligible for medicaid/medikan.

(d) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 4, 1993; amended March 1, 1995; amended July 1, 2002.)

30-10-7. Screening, evaluation, reevaluation, and referral for nursing facilities. (a) In accordance with K.S.A. 39-968 and amendments thereto, each individual seeking admission to a nursing facility or nursing facility for mental health providing care under title XIX of the federal social security act, or seeking referral to home- and community-based services (HCBS), shall receive a preadmission assessment, evaluation, and referral to all available community resources, including nursing facilities, before admission.

(b) Each individual choosing to enter a nursing facility following a preadmission assessment identifying no need for nursing facility placement shall do so as a private-paying resident. Medicaid/medikan shall not participate in the cost of care unless and until a preadmission assessment determines that there is a need for nursing facility placement.

(c) Continued eligibility for services at a nursing facility shall be based on each resident's level of care needs as determined through quarterly reassessments. When the reassessment indicates that the resident's level of care needs no longer meet level of care criteria, the resident shall be considered to be in "resident status review." Payment for services shall continue until the authorized case manager indicates that more appropriate and less intensive

services are available that meet the resident's health, safety, and social needs.

(d) Each individual admitted to a nursing facility for mental health shall be evaluated at least annually upon the anniversary of admission, and at any other time there may have been a significant change in the resident's mental condition. This evaluation shall be made under the supervision of a qualified mental health professional employed by a participating community mental health center, as defined in K.S.A. 59-2946 and amendments thereto, using the screening tool that may be designated by the secretary, to determine whether it is appropriate for that individual to remain in a nursing facility for mental health. Any state-funded individual for whom it is determined that remaining in the facility is inappropriate may be required to have prepared a plan for that individual's transfer to appropriate care.

(e) This regulation shall be effective on and after May 1, 2002. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 39-785; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended May 1, 1976; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-28, Nov. 1, 1985)

TN # MS 02-17 Approval Date SEP 09 2002 Effective Date May 1, 2002 Supersedes #97-04

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14, 1984; amended May 1, 1985; amended May 1, 1986; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1991; amended Jan. 4, 1993; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 30, 1994; amended March 1, 1995; amended Jan. 1, 1997; amended May 1, 2002.)

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30-10-11. Personal needs fund. (a) At the time of admission, each nursing facility provider shall furnish each resident and the resident's representative, if any, with a written statement that meets the following requirements:

(1) Lists all services provided by the provider, distinguishing between those services included in the provider's per diem rate and those services not included in the provider's per diem rate that can be charged to the resident's personal needs fund;

(2) states that there is no obligation for the resident to deposit funds with the provider;

(3) describes each resident's right to select one of the following alternatives for managing the personal needs fund:

(A) The resident or the resident's legal guardian, if any, may receive, retain, and manage the resident's personal needs fund;

(B) the resident may apply to the social security administration to have a representative payee designated for federal or state benefits to which the resident may be entitled; or

(C) except when paragraph (B) of this subsection applies, the resident may designate, in writing, another person to act for the purpose of managing the resident's personal needs fund;

(4) states that any charge for management of a resident's personal needs fund is included in the provider's per diem rate;

(5) states that any late fees, interest, or finance charges shall not be charged to the resident's personal needs fund for

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late payment of the resident liability;

(6) states that the provider is required to accept a resident's personal needs fund to hold, safeguard, and provide an accounting for it, upon the written authorization of the resident or representative, or upon appointment of the provider as the resident's representative payee; and

(7) states that, if the resident becomes incapable of managing the personal needs fund and does not have a representative, the provider shall be required to arrange for the management of the resident's personal funds as provided in subsection (j) .

(b) (1) The provider shall, upon written authorization by the resident, accept responsibility for holding, safeguarding, and accounting for the resident's personal needs fund. The provider may make arrangements with a federally insured or state-insured banking institution to provide these services. However, the responsibility for the quality and accuracy of compliance with the requirements of this regulation shall remain with the provider. The provider shall not charge the resident for these services. Routine bank service charges shall be included in the provider's per diem rate and shall not be charged to the resident. Overdraft charges and other bank penalties shall not be allowable.

(2) The provider shall maintain current, written, and individual records of all financial transactions involving each

resident's personal needs fund for which the provider has accepted responsibility. The records shall include at least the following:

- (A) The resident's name;
  - (B) an identification of the resident's representative, if any;
  - (C) the admission date of the resident;
  - (D) the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction;
  - (E) receipts indicating the purpose for which any withdrawn funds were spent; and
  - (F) the resident's earned interest, if any.
- (3) The provider shall provide to each resident reasonable access to the resident's own financial records.
- (4) The provider shall provide a written statement, at least quarterly, to each resident or representative. The statement shall include at least the following:
- (A) The balance at the beginning of the statement period;
  - (B) total deposits and withdrawals;
  - (C) the interest earned, if any; and
  - (D) the ending balance.
- (c) Commingling prohibited. The provider shall keep any funds received from a resident for holding, safeguarding, and accounting separate from the provider's operating funds, activity

funds, and resident council funds and from the funds of any person other than another resident in that facility.

(d) Types of accounts; distribution of interest.

(1) Petty cash. The provider may keep up to \$50.00 of a resident's money in a non-interest-bearing account or petty cash fund.

(2) Interest-bearing accounts. The provider shall, within 15 days of receipt of the money, deposit in an interest-bearing account any funds in excess of \$50.00 from an individual resident. The account may be an individual account for the resident or may be pooled with other resident accounts. If a pooled account is used, each resident shall be individually identified on the provider's books. The account shall be in a form that clearly indicates that the provider does not have an ownership interest in the funds. The account shall be insured under federal or state law.

(3) The interest earned on any pooled interest-bearing account shall be distributed without reductions in one of the following ways, at the election of the provider:

(A) Prorated to each resident on an actual interest-earned basis; or

(B) prorated to each resident on the basis of the resident's end-of-quarter balance.

(e) The provider shall provide the residents with reasonable access to their personal needs funds. The provider

shall, upon request or upon the resident's transfer or discharge, return to the resident, the legal guardian, or the representative payee the balance of the resident's personal needs fund for which the provider has accepted responsibility, and any funds maintained in a petty cash fund. When a resident's personal needs fund for which the provider has accepted responsibility is deposited in an account outside the facility, the provider, upon request or upon the resident's transfer or discharge, shall within 15 business days return to the resident, the legal guardian, or the representative payee the balance of those funds.

(f) If a provider is a resident's representative payee and directly receives monthly benefits to which the resident is entitled, the provider shall fulfill all of its legal duties as representative payee.

(g) Duties on change of provider.

(1) Upon change of providers, the former provider shall furnish the new provider with a written account of each resident's personal needs fund to be transferred and shall obtain a written receipt for those funds from the new provider.

(2) The provider shall give each resident's representative a written accounting of any personal needs fund held by the provider before any change of provider occurs.

(3) If a disagreement arises regarding the accounting provided by the former provider or the new provider, the resident

shall retain all rights and remedies provided under state law.

(h) Upon the death of a resident who is a recipient of medical assistance, the provider shall take the following actions:

(1) The provider shall in good faith determine or attempt to determine within 30 days from the date of death whether there is a surviving spouse, minor or disabled children, or an executor or administrator of the resident's estate.

(A) If there is an executor or an administrator, the provider shall contact the executor or administrator and convey the monies in the personal needs fund as the executor or administrator directs.

(B) If there is no executor or administrator but there is a surviving spouse, the provider shall contact the surviving spouse and convey the monies in the personal needs fund as that surviving spouse directs.

(C) If there is no executor or administrator or surviving spouse, but there are minor or disabled children, the provider shall contact the guardian or personal representative of the minor or disabled children or, if appropriate, the adult disabled children and convey the monies in the personal needs fund as that person directs.

(D) If there is no surviving spouse, minor or disabled children, or executor or administrator, the provider shall convey within 30 days the personal needs fund to the estate recovery

unit, which shall be responsible for notifying the appropriate court or personal representative of the receipt of the monies from the personal needs fund of the resident.

(2) The provider shall provide the estate recovery unit with a written accounting of the personal needs fund within 30 days of the resident's death. The accounting shall also be provided to the executor or administrator of the resident's estate, if any; the surviving spouse, if any; the guardian or representative of the surviving minor or disabled children, if any; the personal representative of the resident, if any; and the resident's next of kin.

(i) The provider shall purchase a surety bond and submit a report on forms designated by the state licensing agency. The provider shall give assurance of financial security in an amount equal to or greater than the sum of all residents' funds managed by the provider at any time .

(j) If a resident is incapable of managing the resident's personal needs fund, has no representative, and is eligible for supplemental security income (SSI), the provider shall notify the local office of the social security administration and request that a representative be appointed for that resident. If the resident is not eligible for SSI, the provider shall refer the resident to the local agency office, or the provider shall serve as a temporary representative payee for the resident until the actual appointment of a guardian, conservator, or representative

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payee.

(k) Resident property records.

(1) The provider shall maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the provider by the resident.

(2) The property record shall be available to the resident and the resident's representative.

(1) Providers shall keep all personal needs funds in the state of Kansas.

(m) Personal needs funds shall not be turned over to any person other than a duly accredited agent or guardian of the resident. With the consent of the resident, if the resident is able and willing to give consent, the administrator shall turn over a resident's personal needs fund to a designated person to purchase a particular item. However, a signed, itemized, and dated receipt shall be required for deposit in the resident's personal needs fund envelope or another type of file.

(n) A receipt for each transaction shall be signed by the resident, legal guardian, conservator, or responsible party. Recognizing that a legal guardian, conservator, or responsible party is not necessarily available at the time each transaction is made for or on behalf of a resident, the provider shall have a procedure that includes a provision for receipts to be signed on at least a quarterly basis.

(o) The provider shall provide and maintain a system of accounting for expenditures from the resident's personal needs fund. This system shall follow generally accepted accounting principles and shall be subject to audit by representatives of the agency.

(p) Suspension of program payments may be made if the agency determines that any provider is not in compliance with the regulations governing personal needs funds. Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider stating the agency's intent to suspend payments. The notice shall explain the basis for the agency's determination and shall explain the necessary corrective action that shall be completed before payments are released.

(q) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective E-74-43, Aug. 16, 1974; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Jan. 4, 1993; amended Jan. 3, 1994; amended July 1, 2002; amended May 1, 2005.)

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30-10-201 (1)

30-10-201. Intermediate care facilities for mentally retarded. (a) Change of provider.

(1) The current provider or prospective provider shall notify the agency of a proposed change of providers at least 60 days in advance of the closing transaction date. Failure to submit a timely notification shall result in the new provider assuming responsibility for any overpayment made to the previous provider before the transfer. This shall not release the previous provider of responsibility for such overpayment.

(2) Before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the agency shall be notified in writing concerning the change at least 60 days before the change. Failure to submit a timely notification shall result in the new provider assuming responsibility for any overpayment made to the previous provider before the transfer. This shall not release the previous provider of responsibility for such overpayment. The secretary may expressly agree in writing to other overpayment recovery terms.

(3) Any partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the provider of services. Any addition or substitution to a partnership or any change of provider resulting in a completely new partnership shall require that an application to be a provider of services be submitted to the agency.

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30-10-201 (2)

(4) If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of services shall be submitted to the agency.

(5) Transfer of participating provider corporate stock shall not in itself constitute a change of provider. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of provider. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of provider and an application to be a provider of services shall be submitted to the agency.

(6) The change of or a creation of a new lessee, acting as a provider of services, shall constitute a change of provider. An application to be a provider of services shall be submitted to the agency. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in provider.

(b) Each new provider shall be subject to a certification survey by the department of health and environment and, if certified, the period of certification shall be as established by the Kansas department of health and environment. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

IN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-202

30-10-202. ICF-MR provider agreement. As a prerequisite for participation in the medicaid/medikan program as an ICF-MR provider, the owner or lessee shall enter into a provider agreement with the agency on forms prescribed by the secretary. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

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30-10-203

30-10-203. ICF-MR inadequate care. (a) When the agency determines that inadequate care is being provided to a client, payment to the ICF-MR for the client may be terminated.

(b) When the agency receives confirmation from the Kansas department of health and environment that an ICF-MR has not corrected deficiencies which significantly and adversely affect the health, safety, nutrition or sanitation of ICF-MR clients, payments for new admissions shall be denied and future payments for all clients shall be withheld until confirmation that the deficiencies have been corrected. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-204 (1)

30-10-204. ICF-MR standards for participation; intermediate care facility for the mentally retarded or clients with related conditions. As a prerequisite for participation in the medicaid/medikan program as a provider of intermediate care facility services for the mentally retarded or clients with related conditions, each ICF-MR shall: (a) Meet the requirements of 42 CFR 442, subparts A, B, C and E, effective October 3, 1988, which is adopted by reference, and 42 CFR 483, subpart D, effective October 3, 1988, which is adopted by reference; and

(b) be certified for participation in the program by the Kansas department of health and environment. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-205 (1)

30-10-205. ICF-MR admission procedure. (a) Admission procedure for ICF's-MR shall be pursuant to 42 CFR 483.440, effective October 3, 1988, which is adopted by reference.

(b) An ICF-MR shall not require a private-paying client to remain in a private-pay status for any period of time after the client becomes eligible for medicaid/medikan.

(c) Each client shall be screened and found eligible for services before the client is admitted in the medicaid/medikan program. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-206 (1)

30-10-206. ICF-MR certification and recertification by physicians. (a) Certification. At the time of admission to an ICF-MR or at the time any ICF-MR client applies for medical assistance under the medicaid/medikan program, a physician or physician extender shall certify that the services must be given on an inpatient basis. Services shall be furnished under a plan established by the physician or physician extender before authorization of payment. Before reimbursement is approved, a screening team designated by the secretary shall review the physician's or physician extender's certification and shall certify that services in an ICF-MR are the most appropriate services available for the individual. The certification of need shall become part of the individual's medical record. The date of certification shall be the date the case is approved for payment and the certification is signed.

(b) Recertification.

(1) Each ICF-MR shall be responsible for obtaining a physician's or physician extender's recertification for each client.

(2) The recertification shall be included in the client's medical record. Recertification statements may be entered on or included with forms, notes, or other records a physician or physician extender normally signs in caring for a client. The statement shall be authenticated by the actual date and signature of the physician or physician extender.

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-206 (2)

(c) If the appropriate professional refuses to certify or recertify because, in the professional's opinion, the client does not require ICF-MR care on a continuing basis, the services shall not be covered. The reason for the refusal to certify or recertify shall be documented in the client's records. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-207

30-10-207. ICF-MR inspection of care and utilization review.

(a) The inspection of care team from the Kansas department of health and environment shall conduct an inspection of care and utilization review of each medicaid/medikan client in all intermediate care facilities for the mentally retarded certified to participate in the medicaid/medikan program.

(b) Each ICF-MR shall cooperate with authorized representatives of the agency and the department of health and human services in the discharge of their duties regarding all aspects of the inspection of care and utilization review.

(c) Any ICF-MR where the inspection of care team finds inappropriately placed clients shall be responsible for providing transportation for the clients to a more appropriate placement facility. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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30-10-208 (1)

30-10-208. ICF-MR personal needs fund. (a) At the time of admission, ICF-MR providers shall furnish that client and the representative with a written statement that:

(1) Lists all services provided by the provider, distinguishing between those services included in the provider's per diem rate and those services not included in the provider's basic rate, that can be charged to the client's personal needs fund;

(2) states that there is no obligation for the client to deposit funds with the provider;

(3) describes the client's rights to select one of the following alternatives for managing the personal needs fund:

(A) The client may receive, retain and manage the client's personal needs fund or have this done by a legal guardian, if any;

(B) the client may apply to the social security administration to have a representative payee designated for purposes of federal or state benefits to which the client may be entitled;

(C) except when paragraph (B) of this subsection applies, the client may designate, in writing, another person to act for the purpose of managing the client's personal needs fund;

(4) states that any charge for these services is included in the provider's per diem rate;

(5) states that the provider is required to accept a client's personal needs fund to hold, safeguard, and provide an accounting, upon the written authorization of the client or representative, or

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30-10-208 (2)

upon appointment of the provider as a client's representative payee; and

(6) states that, if the client becomes incapable of managing the personal needs fund and does not have a representative, the provider is required to arrange for the management of the client's personal funds as provided in K.A.R. 30-10-208(j).

(b) (1) The provider shall upon written authorization by the client, accept responsibility for holding, safeguarding and accounting for the client's personal needs fund. The provider may make arrangements with a federally or state insured banking institution to provide these services. However, the responsibility for the quality and accuracy of compliance with the requirements of K.A.R. 30-10-208 shall remain with the provider. The provider may not charge the client for these services, but shall include any charges in the provider's per diem rate.

(2) The provider shall maintain current, written, individual records of all financial transactions involving each client's personal needs fund for which the provider has accepted responsibility. The records shall include at least the following:

(A) The client's name;

(B) an identification of client's representative, if any;

(C) the admission date;

(D) the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction;

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(E) receipts indicating the purpose for which any withdrawn funds were spent; and

(F) the client's earned interest, if any.

(3) The provider shall provide each client reasonable access to the client's own financial records.

(4) The provider shall provide a written statement, at least quarterly, to each client or representative. The statement shall include at least the following:

(A) The balance at the beginning of the statement period;

(B) total deposits and withdrawals;

(C) the interest earned, if any, and;

(D) the ending balance.

(c) Commingling prohibited. The provider shall keep any funds received from a client for holding, safeguarding and accounting separate from the provider's operating funds, activity funds, client council funds and from the funds of any person other than another client in that facility.

(d) Types of accounts; distribution of interest.

(1) Petty cash. The provider may keep up to \$50.00 of a client's money in a non-interest bearing account or petty cash fund.

(2) Interest-bearing accounts. The provider shall, within 15 days of receipt of the money, deposit in an interest-bearing account any funds in excess of \$50.00 from an individual client. The account may be individual to the client or pooled with other

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client accounts. If a pooled account is used, each client shall be individually identified on the provider's books. The account shall be in a form that clearly indicates that the provider does not have an ownership interest in the funds. The account shall be insured under federal or state law.

(3) The interest earned on any pooled interest-bearing account shall be distributed in one of the following ways, at the election of the provider:

(A) Pro-rated to each client on an actual interest-earned basis; or

(B) pro-rated to each client on the basis of the client's end-of-quarter balance.

(e) The provider shall provide the clients with reasonable access to their personal needs funds. The provider shall, upon request or upon the client's transfer or discharge, return to the client, the legal guardian or the representative payee the balance of the client's personal needs fund for which the provider has accepted responsibility, and any funds maintained in a petty cash fund. When a client's personal needs fund for which the provider has accepted responsibility is deposited in an account outside the facility, the provider, upon request or upon the client's transfer or discharge, shall within 15 business days, return to the client, the legal guardian, or the representative payee, the balance of those funds.

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(f) When a provider is a client's representative payee and directly receives monthly benefits to which the client is entitled, the provider shall fulfill all of its legal duties as representative payee.

(g) Duties on change of provider.

(1) Upon change of providers, the former provider shall furnish the new provider with a written account of each client personal needs fund to be transferred, and obtain a written receipt for those funds from the new provider.

(2) The provider shall give each client's representative a written accounting of any personal needs fund held by the provider before any change of provider occurs.

(3) In the event of a disagreement with the accounting provided by the previous provider or the new provider, the client shall retain all rights and remedies provided under state law.

(h) Upon the death of a client, the provider shall provide the executor or administrator of a client's estate with a written accounting of the client's personal needs fund within 30 business days of a client's death. If the deceased client's estate has no executor or administrator, the provider shall provide the accounting to:

- (1) The client's next of kin;
- (2) the client's representative; and
- (3) the clerk of the probate court of the county in which the client died.

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(i) The provider shall purchase a surety bond or employee indemnity bond, or submit a letter of credit or individual or corporate surety, to guarantee the security of clients' funds when the amount in the aggregate exceeds \$1,000.00. The guarantee requirement shall not exceed the highest quarterly balance from the previous year.

(j) If a client is incapable of managing the client's personal needs fund, has no representative, and is eligible for SSI, the provider shall notify the local office of the social security administration and request that a representative be appointed for that client. If the client is not eligible for SSI, the provider shall refer the client to the local agency office, or the provider shall serve as a temporary representative payee for the client until the actual appointment of a guardian or conservator or representative payee.

(k) Client property records.

(1) The provider shall maintain a current, written record for each client that includes written receipts for all personal possessions deposited with the provider by the client.

(2) The property record shall be available to the client and the client's representative.

(1) Providers shall keep the funds in the state of Kansas.

(m) Personal needs fund shall not be turned over to any person other than a duly accredited agent or guardian of the client. With the consent of the client, if the client is able and willing to

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30-10-208 (7)

give consent, the administrator shall turn over a client's personal needs fund to a designated person to purchase a particular item. However, a signed, itemized, and dated receipt shall be required for deposit in the client's personal needs fund envelope or another type of file.

(n) Receipts shall be signed by the client, legal guardian, conservator or responsible party for all transactions. Recognizing that a legal guardian, conservator or responsible party may not be available at the time each transaction is made for or on behalf of a client, the provider shall have a procedure which includes a provision for signed receipts at least quarterly.

(o) The provider shall provide and maintain a system of accounting for expenditures from the client's personal needs fund. This system shall follow generally accepted accounting principles and shall be subject to audit by representatives of the agency. The effective date of this regulation shall be October 1, 1990. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990.)

TN#MS-90-48 Approval Date 1/14/91 Effective Date 10/1/90 Supersedes Nothing

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Revision: HCFA-PM-92-4  
August 1992

(HSQB)

State/Territory: Kansas

Citation

1902(y)(1),  
1902(y)(2)(A),  
and Section  
1902(y)(3)  
of the Act  
(P.L. 101-508,  
Section 4755(a)(2))

1902(y)(1)(A)  
of the Act

1902(y)(1)(B)  
of the Act

1902(y)(2)(A)  
of the Act

Sanctions for Psychiatric Hospitals

- (a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
- (b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
- (c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:
1. terminate the hospital's participation under the State plan; or
  2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
  3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
- (d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: KansasCitation1932(e)  
42 CFR 438.726Sanctions for MCOs and PCCMs

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
  - Imposes on enrollees, premiums or charges in excess of permitted charges.
  - Acts to discriminate among enrollees on the basis of their health status or need for health care services.
  - Misrepresents or falsifies information that it furnishes to CMS or to the State.
  - Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
  - Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210
  - Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
  - Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Intermediate Sanctions that may be imposed:

- Civil Monetary Sanctions,
- Temporary Management: The State shall impose temporary management in the event it finds that the MCO has repeatedly failed to meet substantive requirements in section 1903 (m) or

TN # #03-08  
Supersedes TN # NoneEffective Date August 1, 2003  
Approval Date August 28, 2003

State: KansasCitationIntermediate Sanctions (continued)

42 CFR 438.726

section 1932 of the Act. The MCO shall recognize the authority of temporary management appointed to oversee MCO. The State shall not delay imposition of temporary management to provide hearing prior to imposing this sanction. The State shall not terminate temporary management until such time that it determines that the MCO can ensure that the sanctioned behavior will not recur. In the event that the State shall impose temporary management, the State shall also grant enrollees the right to terminate enrollment without cause and shall notify the affected enrollees of their right to terminate enrollment.

- Suspension of all new enrollment, including default enrollment, after the effective date of the sanction,
- Termination: Termination of the Contract for failure to carry out the substantive terms of this contract or to meet applicable requirements in section 1932, 1903(m) and 1905(t) of the Act.

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

\_\_\_\_ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

Revision: HCFA-PM-86-9 (BERG)  
MAY 1986

ATTACHMENT 4.32-A  
Page 1  
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES  
REQUESTS TO OTHER STATE AGENCIES

Information will be requested from the following 3 agencies:

1. Kansas Department of Human Resources - Wages and unemployment benefits.
2. Social Security Administration - Benefits and earnings via BENDEX.
3. Internal Revenue Service - Unearned income.

TN No. MS-86-26  
Supersedes  
TN No. neu

Approval Date 9/14/86

Effective Date 10-1-86

HCFA ID: 0123P/0002P

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

ATTACHMENT 4.33-A  
Page 1  
OMB No: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS  
TO HOMELESS INDIVIDUALS

For persons eligible for Medicaid and who do not reside in a permanent dwelling, or do not have a fixed home or mailing address, the agency will have the medical identification card sent to the local office so that the eligible individual may receive it in person. When deemed appropriate, the agency may use other modes of delivery such as post office boxes, General Deliveries, or addresses of friends or relatives.

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TN No. MS-87-24  
Supersedes  
TN No. none

Approval Date AUG 05 1987

Effective Date April, 87

HCFA ID: 1080P/0020P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS  
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

DESCRIPTION OF THE LAW OF KANSAS  
CONCERNING ADVANCE DIRECTIVES

There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions."

The Kansas Natural Death Act, K.S.A. 64-28,106, et seq.

This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may make a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will." The declaration must be:

1. In writing;
2. Signed by the adult making the declaration;
3. Dated; and
4. Signed in front of two adult witnesses.

There are specific rules set out in the law about the signature in case of an adult who can't write. There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may not serve as witnesses. A woman who is pregnant may not make a declaration.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS  
FOR MEDICAL ASSISTANCE

The declaration may be revoked in three ways:

1. By destroying the declaration;
2. By signing and dating a written revocation; and
3. By speaking an intent to revoke in front of an adult witness. The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two physicians must examine the patient and diagnose that the patient has a terminal condition.

The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid.

The Kansas Natural Death Act imposes duties on physicians and provides penalties for violations of the laws about declaration.

The Kansas Durable Power of Attorney for Health Care Decisions Law,  
K.S.A. 58-625, et seq.

A "durable power of attorney for health care decisions" is a written document in which an adult gives another adult (called an "agent") the right to make health care decisions. The power of attorney applies to health care decisions even when the adult is not in a terminal condition. The adult may give the agent the power to:

1. Consent or to refuse consent to medical treatment;
2. Make decisions about donating organs, autopsies, and disposition of the body;
3. Make arrangements for hospital, nursing home, or hospice care;
4. Hire or fire physicians and other health care professionals; or
5. Sign releases and receive any information about the adult.

A "durable power of attorney for health care decisions" may give the agent all those five powers or may choose only some of the powers. The power of attorney may not give the agent the power to revoke the adult's declaration under the Kansas Natural Death Act ("living will"). The power of attorney only takes effect when the adult is disabled unless the adult specifies that the power of attorney should take effect earlier.

TN No. MS-91-44  
Supersedes Nothing Approval Date DEC 20 1991 Effective Date 10/01/91  
TN No. Nothing

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS  
FOR MEDICAL ASSISTANCE

The adult may not make a health care provider treating the adult the agent except in limited circumstances.

The power of attorney may be made by two methods:

1. In writing;
2. Signed by the adult making the declaration;
3. Dated;
4. Signed in front of two adult witnesses;

Or:

Written and notarized.

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may not serve as witnesses.

The adult, at the time the power of attorney is written, should specify how the power of attorney may be revoked.

The Patient Self-Determination Act, Sections 4206 & 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508

This federal law begins December 1, 1991. It applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives.

This law also required that each state develop a written description of the State law about advance directives. This description was written by the Medical Services Section of the Kansas Department of Social and Rehabilitation Services to comply with that requirement. If you have any questions about your rights to decide about health care and to make advance directives, please consult with your physician or attorney.

TN No. MS-91-44

Supersedes

TN No. Nothing

Approval Date

DEC 20 1991

Effective Date

10/01/91

HCFA ID: 7982E

Revision: HCFA-PM-95-4 (HSQB)  
June 1995

Attachment 4.35-A  
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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The State uses additional factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

Revision: HCFA-PM-95-4 (HSQB)  
June 1995

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

---

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

The State of Kansas uses Receivership as the method of imposing Temporary Management. This method is described in Kansas Statutes Annotated, 39-954 through 39-964. These Statutes are attached as Supplement 1 to Attachment 4.35-C.

## RECEIVERSHIP

**KSA 39-954. Application for receiver; order appointing; qualifications of persons designated and method of selection, rules and regulations.** (a) The secretary of health and environment, the owner of an adult care home, or the person licensed to operate an adult care home may file an application with the district court for an order appointing the secretary of health and environment or the designee of the secretary as receiver to operate an adult care home whenever:

- (1) Conditions exist in the adult care home that are life threatening or endangering to the residents of the adult care home;
- (2) the adult care home is insolvent; or
- (3) the secretary of health and environment has issued an order revoking the license of the adult care home.

(b) The secretary of health and environment may adopt rules and regulations setting forth the necessary qualifications of persons designated receivers and a method for selecting designees.

**History:** L. 1978, ch. 162, sec. 1; L. 1985, ch. 151, sec. 1; July 1.

**KSA 39-955. Filing application for receivership; contents.** The application for receivership shall be filed in the district court in the county where the adult care home is located. The application shall be verified and set forth the specific reasons therefor.

**History:** L. 1978, ch. 162, sec. 2; July 1.

**KSA 39-956. Service of copies of application for receivership; posting in adult care home.** The applicant shall serve those persons set forth in K.S.A. 39-954 with copies of the application. Service of process shall be as provided for under the code of civil procedure. The applicant shall also send five (5) copies of the application for receivership to the adult care home. The adult care home shall post the copies of the application in conspicuous places within the adult care home.

**History:** L. 1978, ch. 162, sec. 3; July 1.

**KSA 39-957. Answer to application for receivership.** A party shall file an answer to the application within five (5) days after the service of the application upon such person.

**History:** L. 1978, ch. 162, sec. 4; July 1.

**KSA 39-958. Priority of application for receivership in district court; evidence; appointment of receiver; certain statutes inapplicable to license granted receiver; length of license.** The application for receivership shall be given priority by the district court and shall be heard no later than the seventh (7th) day following the filing of the application. A continuance of no more than ten (10) days may be granted by the district court for good cause. The district court shall give all parties who have filed an answer the opportunity to present evidence pertaining to the application. If the district court finds that the facts warrant the granting of the application, the court shall appoint the secretary of health and environment or the designee of the secretary as receiver to operate the home.

Upon the appointment of a receiver under this section, the receiver shall be granted a license by the licensing agency to operate an adult care home as provided under the provisions of article 9 of chapter 39 of the Kansas Statutes Annotated, and acts amending the provisions thereof or acts supplemental thereto. The provisions of article 9 of chapter 39 of the Kansas Statutes Annotated, and acts amending the provisions thereof and acts supplemental thereto, relating to inspection prior to granting a license to operate an adult care home and relating to payment of license fees shall not apply to a license granted to a receiver under this section, and such license shall remain in effect during the existence of the receivership and shall expire on the termination of the receivership. The receiver shall make application for the license on forms provided for this purpose by the licensing agency.

**History:** L. 1978, ch. 162, sec. 5; July 1.

**KSA 39-959. Powers and duties of receiver.** A receiver appointed in accordance with the provisions of this act shall have the following powers and duties: (a) Conduct the day to day business operations of the adult care home;

(b) reimburse the owner or licensee, as appropriate, a fair monthly rental for the adult care home, taking into account all relevant factors, including the condition of such adult care home and set-offs arising from improvements made by the receiver;

(c) give fair compensation to the owner or licensee, as appropriate, for all property taken or used during the course of the receivership if such person has not previously received compensation for the property being taken or used;

(d) correct or eliminate any deficiency in the adult care home that concerns the health, safety, nutrition, or sanitation of the residents of the adult care home and is life threatening or endangering;

(e) enter into contracts as necessary to carry out his or her duties as receiver and incur expenses for individual items of repairs, improvements or supplies without the procurement of competitive bids, if otherwise required by law where the total amount of such individual item does not exceed five hundred dollars (\$500);

(f) collect incoming payments from all sources and apply them to the costs incurred in the performance of his or her functions as receiver including the compensation of the receiver, if any;

(g) honor all existing leases, mortgages, chattel mortgages and security interests;

(h) operate the adult care home so as to provide safe and adequate health care for the residents of the adult care home;

(i) provide for the orderly transfer of all residents in the adult care home to other adult care homes or make other provisions for their continued safety and health care, as necessary;

(j) other powers and duties as authorized or imposed by the district court.

**History:** L. 1978, ch. 162, sec. 6; July 1.

**KSA 39-960. Expenditures from monies appropriated for purposes of act; when authorized; repayment.** The secretary of social and rehabilitation services, upon request of a receiver, may authorize expenditures from money appropriated for purposes set forth in this act if incoming payments from operation of the adult care home are less than the cost incurred by the receiver in the performance of the receiver's functions as receiver or for purposes of initial operating expenses of the receivership. Any payments made by the secretary of social and rehabilitation services pursuant to this section shall be owed by the owner or licensee and repaid to the secretary of social and rehabilitation services when the receivership is terminated pursuant to K.S.A. 39-963 and amendments thereto and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.

**History:** L. 1978, ch. 162, sec. 7; L. 1984, ch. 158, sec. 1; July 1.

**KSA 39-961. Department of health and environment to assist receiver; expenses of department; repayment.** The personnel and facilities of the department of health and environment shall be available to the receiver for the purposes of carrying out the receiver's duties as receiver as authorized by the secretary of health and environment.

The department of health and environment shall itemize and keep a ledger showing costs of personnel and other expenses establishing the receivership and assisting the receiver and such amount shall be owed by the owner or licensee to the department of health and environment. Such department shall submit a bill for such expenses to the receiver for inclusion in the receiver's final accounting. Any amount so billed and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.

**History:** L. 1978, ch. 162, sec. 8; L. 1984, ch. 158, sec. 2; July 1.

**KSA 39-962. Supervision of district court; final accounting; removal.** The receiver shall be subject to the supervision of the district court. The receiver shall file a final accounting with the district court upon the termination of the receivership. The receiver shall be subject to removal by the district court for good cause.

**History:** L. 1978, ch. 162, sec. 9; July 1.

**KSA 39-963. Termination of receivership; circumstances; accounting and disposition of money; court orders for recovery of certain expenses and costs.** (a) The court shall terminate the receivership only under any of the following circumstances:

- (1) Twenty-four months after the date on which the receivership was ordered;
- (2) a new license, other than the license granted to the receiver under K.S.A. 39-958 and amendments thereto, has been granted to operate the adult care home; or
- (3) at such time as all of the residents in the adult care home have been provided alternative modes of health care, either in another adult care home or otherwise.

(b) At the time of termination of the receivership, the receiver shall render a full and complete accounting to the district court and shall make disposition of surplus money at the direction of the district court.

The court may make such additional orders as are appropriate to recover the expenses and costs to the department of health and environment and the secretary of social and rehabilitation services incurred pursuant to K.S.A. 39-960 or 39-961 and amendments thereto.

**History:** L. 1978, ch. 162, sec. 10; L. 1984, ch. 158, sec. 3; July 1.

**KSA 39-964. Procedures for and review and enforcement of administrative actions.** (a) The provisions of the Kansas administrative procedure act and the act for judicial review and civil enforcement of agency actions shall govern all administrative proceedings conducted pursuant to K.S.A. 39-945 through 39-963, and amendments thereto, except to the extent that the provisions of the above-named acts would conflict with the procedures set forth in the above-mentioned statutes.

(b) This section shall be a part of and supplemental to article 9 of chapter 39 of the Kansas Statutes Annotated.

**History:** L. 1984, ch. 313, sec. 69; July 1, 1985.

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Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

In accordance with Kansas Statutes Annotated (K.S.A.) 39-953a, Kansas also imposes the following remedies:

**Order prohibiting new admissions to adult care homes; when issued; proceedings; remedy not limiting.** (a) At any time the secretary of health and environment initiates any action concerning an adult care home in which it is alleged that there has been a substantial failure to comply with the requirements, standards or rules and regulations established under the adult care home licensure act, that conditions exist in the adult care home which are life threatening or endangering to the residents of the adult care home, that the adult care home is insolvent, or that the adult care home has deficiencies which significantly and adversely affect the health, safety, nutrition or sanitation of the adult care home residents, the secretary may issue an order, pursuant to the emergency proceedings provided for under the Kansas administrative procedure act, prohibiting any new admissions into the adult care home until further determination by the secretary. This remedy granted to the secretary is in addition to any other statutory authority the secretary has relating to the licensure and operation of adult care homes and is not to be construed to limit any of the powers and duties of the secretary under the adult care home licensure act.

Revision: HCFA-PM-95-4 (HSQB)  
June 1995

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Page 1  
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Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)  
June 1995

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State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)), for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)  
June 1995

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Transfer of residents: Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

I. Policy - Directed Plan of Correction

This policy is to implement the regulatory requirements at 42 CFR 488.424 for imposing a "directed plan of correction." A directed plan of correction is one of the Category 1 remedies the Bureau of Adult and Child Care (BACC) or the Health Care Financing Administration (HCFA) Regional Office can select when it finds a facility out of compliance with federal requirements.

Purpose

A directed plan of correction is a specific plan which BACC or the HCFA Regional Office develops that requires a facility to take action within specified time frames. The purpose of the directed plan of correction is to achieve correction and continued compliance with federal requirements.

Process

1. The directed plan of correction can be developed by BACC, the HCFA Regional Office, or the temporary manager - not the facility.
2. A directed plan of correction may be imposed 15 days after the facility receives notice for non-immediate jeopardy situations and two days after the facility receives notice for immediate jeopardy situations. The date the directed plan of correction is imposed does not mean that all corrections must be completed by that date.
3. Use of a directed plan of correction should be dependent upon causes identified by BACC, the HCFA Regional Office, SRS, or a temporary manager (with BACC, HCFA Regional Office, or SRS approval).
4. The elements of a directed plan of correction are:
  - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;
  - How the facility will identify other residents having the potential to be affected by the same deficient practice;
  - What measures will be put into place for systemic changes made to ensure the deficient practice will not recur;

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- How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the systemic change);
  - When corrective actions must be accomplished; and
  - How substantial compliance will be measured.
5. Achieving compliance is the provider's responsibility. If the facility fails to achieve substantial compliance after complying with the directed plan of correction, BACC, the HCFA Regional Office, or SRS may impose another remedy until the facility achieves substantial compliance or is terminated from the Medicare or Medicaid program.

II. Policy - Directed Inservice Training

This policy is to implement the regulatory requirements at 42 CFR 488.425 for imposing "directed inservice training." Directed inservice training is one of the Category I remedies the Bureau of Adult and Child Care (BACC) or the Health Care Financing Administration (HCFA) Regional Office can select when they find a facility out of compliance with federal requirements.

Purpose

The purpose of directed inservice training is to provide basic knowledge to achieve compliance and remain in compliance with federal requirements.

Process

1. BACC's administrative staff, the HCFA Regional Office, or the State Department of Social and Rehabilitation Services (SRS) will determine when this type of remedy will be imposed.
2. Directed inservice training may be imposed 15 days after the facility receives notice of situations where there is no immediate jeopardy and 2 days after the facility receives notice for immediate jeopardy situations.
3. The facility will be notified in writing (along with other requirements or remedies as determined) by the administrative staff of BACC or HCFA Regional Office about what topics and type(s) of directed inservice training the facility must provide to its staff. It is the facility's responsibility to ensure that the appropriate staff attend the outlined inservice training program.

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4. Educational sources that need to be utilized when a directed inservice training program is required include, but is not limited to:
  - Programs developed by well established centers for geriatric health services education;
  - Schools of nursing or medicine;
  - Centers for aging;
  - Health education centers that have established programs in geriatrics and geriatric psychiatry; and/or
  - The ombudsman program.
  - Qualified consultants.
5. The facility will bear the expense of the directed inservice training.
6. Achieving compliance is the provider's responsibility. If the facility fails to achieve substantial compliance after complying with a directed inservice training, BACC, the HCFA Regional Office, or SRS may impose another remedy until the facility achieves substantial compliance or is terminated from the Medicare or Medicaid program.
7. After the training has been completed, BACC Field Services staff will assess whether compliance has been achieved. If the facility still has not achieved substantial compliance, the state Medicaid agency or the HCFA Regional Office may impose one or more additional remedies as specified in 42 CFR 488.406.

III. Policy - State Monitoring

This policy is to implement the regulatory requirements at 42 CFR 488.422 for imposing "state monitoring." State monitoring is one of the Category I remedies the Bureau of Adult and Child Care (BACC) or the Health Care Financing Administration (HCFA) Regional Office can select when they find a facility out of compliance with federal requirements.

Purpose

The purpose of a state monitor or state monitoring is to oversee the correction of cited deficiencies in the facility as a safeguard against further harm to the residents when harm or a situation with a potential for harm has occurred.

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Process

1. Monitors are identified by BACC as appropriate professionals who will be responsible for monitoring cited deficiencies in a manner determined by BACC.

State monitoring is a process developed by BACC as an appropriate method or means by which cited deficiencies will be monitored.

2. A state monitor is an employee or a contract employee of BACC. (A contract employee may be retained by BACC if the necessary federal funds have been allocated to hire a contract employee.) The monitor will not be an employee or contractor of the monitored facility nor will this individual have an immediate family member as a resident in the monitored facility.

3. State monitoring will not be imposed on a facility when that facility has been found on three consecutive standard surveys to have provided substandard quality of care and/or as a selected Category I remedy for deficiencies rate "D" or "E" on the scope and severity scale. Otherwise, state monitoring may be considered an optional remedy. Some situations in which state monitoring may be appropriate include, but are not limited to, the following:

- Poor facility history (i.e., a pattern of poor quality of care, many complaints);
- BACC has concerns that the situation in the facility has the potential to worsen;
- Immediate jeopardy exists and no temporary manager can be appointed;
- If the facility refuses to relinquish control to a temporary manager, a monitor may be imposed to oversee termination procedures and transfers of residents; or
- The facility seems unable or unwilling to take corrective action for cited substandard quality of care.

4. State monitors will have complete access to all areas of a facility.

5. Factors that will be used to decide how often a facility is monitored may include:

- The nature and seriousness of the deficiency(ies) as specified by BACC; and/or
- The timing and frequency of when the problems occurred (i.e., mealtimes, evening shifts, daily, etc.)

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6. When state monitoring is imposed as a remedy, BACC may select one or more of the following methods of state monitoring:
- Assignment of a revisit or revisits;
  - A state monitor to do onsite visits on a routine regular basis (weekly, monthly, or quarterly);
  - A state monitor to perform random visits to the facility;
  - Any other methods of state monitoring developed by BACC.
7. The remedy will be discontinued when a facility has:
- Its provider agreement discontinued; and/or
  - Demonstrated to the satisfaction of HCFA or BACC that the facility is in substantial compliance with requirements (if imposed for repeated substandard quality of care) that the facility will remain in substantial compliance.

IV. Policy - Conflict Prevention

In order to develop, implement, and cultivate a survey process for all types of providers which minimizes conflict between provider and survey agency, and to provide an opportunity for resolution of disagreements in a non-adversarial manner, the following procedure is adopted:

Process

1. Each surveyor is responsible to conduct the survey in a professional and amicable manner, including the establishment of a dialogue concerning findings identified by the survey process. The facility is responsible for the same professional and amicable conduct.
2. At the entrance conference, the survey team leader will provide the administrator with the list of materials needed to conduct the survey and a copy of this policy. The facility will provide information concerning where required items can be found.

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3. The surveyor is responsible to conduct a daily meeting with the administrator (or designated staff) to discuss the process of the survey, items not found, and areas where additional information may be needed. Facility staff should be prepared to present documentation from professional journals and references to support standard of care decisions. Examples of documentation would be a new pressure ulcer treatment regime or a method to deal with the behavior of a resident. The surveyor shall consider these sources before making final deficiency decisions. The regional manager may be contacted by the surveyor to discuss issues which need resolution during the survey.
4. The facility may present additional information during the scheduled exit conference. The surveyor shall consider this information in determining whether to retain a deficiency in question. The exit conference shall not be unduly delayed for this process. The facility shall have the opportunity to provide additional information through the plan of correction process. Pursuant to federal survey policy, surveyors are required to cite deficiencies even if the facility corrects the problem during the survey. The surveyor may note on the Statement of Deficiencies that the facility has initiated corrective action.
5. Upon termination of the exit conference, the surveyor will ask the facility to complete the comment form. The facility can indicate on the comment form issues of survey procedure or deficiency that may need resolution.
6. Upon receipt of the survey report, the regional manager will mail the questionnaire to the administrator asking for comments on the survey process. This questionnaire will be returned to the Topeka Office for review.
7. If the administrator does not believe their concerns about a deficiency or a procedure have been appropriately addressed, the regional manager may be contacted.
8. Informal conflict prevention (informal dispute resolution) is also required by 42 CFR 488.331. Requests for conflict prevention must be submitted in writing which includes an explanation of the specific deficiencies that are being disputed. The request must be made within 10 calendar days from the exit conference. If the same deficiency has been disputed on survey it cannot be disputed again on revisit. This request should be submitted to the Regional Manager. The regional manager will review the deficiency or deficiencies and may contact the surveyor for additional information.

Informal conflict prevention may be by telephone, in writing, or in a face-to-face meeting with the regional manager.

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Use of informal conflict prevention does not delay formal imposition of remedies. It also cannot be used to challenge any other aspect of the survey process other than to dispute deficiencies. Aspects of the survey process which cannot be disputed include classification of deficiencies, i.e., scope and harm assessment (SNFs & NFs); failure of survey team in citing deficiencies among facilities; or the inadequacy or inaccuracy of the informal conflict prevention process.

When a provider is unsuccessful during the process at demonstrating that a deficiency should not have been cited, they will be notified in writing by the regional manager that they were unsuccessful.

When a provider is successful, the deficiency will be marked "deleted," signed, and dated by the regional manager and any enforcement action imposed solely because of the deficiency citation will be rescinded. If a "clean" (new) 2567 is requested, a new "clean" plan of correction must be submitted.

9. Regulation interpretations will be developed as appropriate in response to issues raised by administrators and survey staff.

Official regulation interpretations will be signed off by the director of the Adult Care Home Program, MH/MR director, or Hospital Program director and director of the Bureau of Adult and Child Care.

V. Policy - Alternative Sanctions

The state is permitted to continue alternative sanctions in addition to those noted in the Act through the application of KSA 39-945, 946, 947, 948, 949, 951, 952, 953a, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, and 965 to all nursing facilities participating in the medicaid program.

VI. Policy - Provisional Licensure

The state is permitted to continue issuing Provisional Licenses through the application of KSA 39-929 which states, "A provisional license may be issued to any adult care-home, the facilities of which are temporarily unable to conform to all the standards, requirements, rules and regulations established under the provisions of this act: Provided, however, that the issuance of such provisional license shall be approved by the state fire marshal. A provisional license may be issued to provide time to make necessary corrections for not more than six (6) months. One additional successive six-month provisional license may be granted at the discretion of the licensing agency. A change of ownership during the provisional licensing period will not extend the time for requirements to be met that were the basis for the provisional license nor entitle the new owner to an additional provisional license.

Revision: HCFA-PM-95-4 (HSQB)  
June 1995

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Discussion

The Kansas Department of Health and Environment believes that the primary purpose of the survey process is to assure that resident/patients/clients are receiving the care and services required to assist them to function at the highest practicable level. It is the intent of this Department to conduct surveys in a fair and factual manner. There will be instances in this process when disagreements will occur between the surveyor(s) and facility staff. The above procedure will be followed during the survey process to ensure that potential areas of conflict are minimized and disagreements are resolved in a non-adversarial manner.

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DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The registry contains the person's full name; identification factors (social security number, certification number; birth date and address); certification date which is date eligible and placed on the registry; any findings of fact by a final order of abuse, neglect or exploitation by a CNA or CNA trainee; whether the hearing was waived or conducted; hearing date, if any; and any disputing statement by a CNA once a finding of fact becomes a final order.

TN No. MS-92-05  
Supersedes  
TN No. Nothing

Approval Date MAR 27 1992

Effective Date 01/01/92

HCFA ID:

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COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Other information on the registry: person's phone number, approved-course information; examination scores; approved instructor information; examination site; the initial beginning date of course the person took; refresher course information; certificate replacements information; facility information; and information on confirmation letters issued to facilities to document compliance with contacting the registry. The same information is on the register for home health aides and certified nurse aides - medication aides.

TN No. MS-92-05  
Supersedes  
TN No. Nothing

Approval Date MAR 27 1992

Effective Date 01/01/92

HCFA ID:

## KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM-93-1 (BPD)  
January 1993

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Page 1

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

#### DEFINITION OF SPECIALIZED SERVICES

##### Specialized Services for Individuals with Mental Illness

Specialized services for individuals with mental illness are those services which necessitate the availability of trained mental health personnel from a licensed provider. These services can be provided in the following settings:

1. An acute care psychiatric hospital; OR
2. Community setting if the service provided is equivalent to the level of services provided in an acute care psychiatric hospital.

##### Specialized Services for Individuals with Mental Retardation or Related Condition

Specialized services for mental retardation and related conditions are those services which necessitate the availability of trained MR personnel from a licensed provider. These services can be provided in the following settings:

1. Intermediate Care Facility for Mental Retardation (ICF/MR); OR
2. Community setting if the service provided is equivalent to the level of services provided in an ICF/MR.

Revision: HCFA-PM-92-3 (HSQB)  
APRIL 1992

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Survey and Certification Education Program

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The State has in effect the following survey and certification periodic educational program for staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

In accordance with its interagency agreement with the Kansas Department of Social and Rehabilitation Services, the Kansas Department of Health and Environment (KDHE) will conduct small group workshops for nursing facility staff to provide instruction in the use of the Resident Assessment Instrument.

KDHE will present training seminars concerning current nursing facility regulations to provider organizations such as Kansas Association of Homes for the Aging and the Kansas Health Care Association, to professional groups such as the Kansas Pharmacy Association and the Kansas Medical Society, and to caregiver/family groups.

KDHE provides each nursing facility with a poster explaining abuse, neglect, and exploitation policies. The poster includes a number to call to report complaints of abuse, neglect, or exploitation or to ask questions.

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TN# MS-92-18 Approval Date AUG 06 1992 Effective Date JUL 01 1992 Supersedes TN# Nothing  
HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-3 (HSQB)  
APRIL 1992

Attachment 4.40-B  
Page 1  
OMB No.:

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Process for the Investigation of Allegations of Resident Neglect  
and Abuse and Misappropriation of Resident Property

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

See Attached Pages

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TN# MS-92-18 Approval Date AUG 06 1992 Effective Date \_\_\_\_\_ Supersedes TN# Nothing  
JUL 01 1992 HCFA ID: \_\_\_\_\_

KANSAS MEDICAID STATE PLAN

Attachment 4.40-B  
Page 2  
OMB No.:

Number:  
Date: October 1, 1990  
Subject: Abuse, Neglect, Exploitation  
Policy Superseded: None

Policy Statement

All reports of abuse, neglect or exploitation from any source regarding care of Adult Care Home residents or Medical Care Facility patients received by Kansas Department of Health and Environment (KDHE), Bureau of Adult & Child Care (BACC), shall be assigned for investigation, and entered into the record. All confirmed nurse aide perpetrators will be referred to Health Occupations Credentialing to be listed in the Aide Registry and other confirmed licensed perpetrators will be referred to their regulatory agency.

Procedure

1. All reports regarding abuse, neglect or exploitation shall be referred for receiving in the following order:
  - a) Administrator of Complaint Programs
  - b) Field Services Program Coordinator
  - c) Field Services RN
  - d) Consultant Nurse
  - e) Consultant Dietitian
  - f) all other professional staff
  - g) all other clerical staff
2. Form I shall be used to receive all reports.
  - a. Any person receiving a telephone call or personal visit report shall utilize Form I for the recording of pertinent information in identifying the issues of the report.
  - b. Written reports are to be reviewed by the Program Administrator and Form I is to be completed.
3. The program administrator or designee shall assign an identification number to each report and enter the reports in the master abuse, neglect, exploitation log. The program administrator shall complete lines 1, 2, & 3, Form I.
4. The program administrator will assign the complaint by a priority system. Complaints will be given a priority one (1) when a resident is considered to be in a life threatening situation. Priority two (2) will be when a resident is in eminent danger of harm from the allegation. The third (3) priority will include all other complaints which will be investigated under the regular complaint policy. The assignor will include the priority code on the report for investigation (Form I) and will notify the appropriate supervisor regarding scheduling. Personal contact with the resident/patient shall

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be made immediately for all priority one (1) complaints and by the end of the next working day for all priority two (2) complaints. The priority three (3) complaints will follow the regular policy. Personal contact will be made in person or by telephone depending on the situation and the judgement of the supervisor. The investigation must be completed within 14 days of the date the complaint is originally received in the Topeka office for all priority 1 & 2 complaints and according to the regular complaint policy for all priority 3 complaints.

5. The investigator shall conduct the investigation in the following manner:
  - a. The facility administrator, or person in charge the day of the investigation, shall be advised a report is being investigated. The investigator shall maintain confidentiality of the reporter and specific complaint details.
  - b. Investigative techniques used in the process shall include, but are not limited to, interviews with residents/patients, staff or others; review of policies and procedures and records; investigators observation of practices; or any method appropriate to facilities gathering information.
  - c. If the resident is found to be in immediate jeopardy, the investigator will contact their supervisor or designee immediately by telephone. Upon notification, the supervisor will immediately contact the program administrator or designee by telephone that the resident is in immediate jeopardy and list specific concerns.
  - d. The investigator shall complete the investigation within 14 days of the report being received in the Topeka Office and forward completed Forms I, II, & III to their supervisor immediately.
  - e. If violation of licensure and/or certification laws are found, the investigator shall write deficiencies in accordance with the survey procedure.
  - f. The supervisor shall forward all report documentation to the program administrator by the date listed on line 3, page 3, Form I.
6. The program administrator shall review findings and respond to all parties within 3 working days. The program administrator shall forward to the Field Services Program Coordinator any investigation findings resulting in cited deficiencies or any confirmed reports of abuse, neglect and exploitation.

TN#MS-92-18 Approval Date            <sup>AVE 0 6 1992</sup> Effective Date JUL 0 1 1992 Superseded TN#Nothing  
HCFA ID:

KANSAS MEDICAID STATE PLAN

Attachment 4.40-B  
Page 4  
OMB NO:

7. The program administrator will determine the need for protective services from the report and will refer all such cases to the Kansas Department of Social and Rehabilitation Services (SRS) using Form IV and other appropriate documentation within 3 working days. If the resident is found to be in immediate jeopardy the program administrator will contact the SRS program administrator or their designee immediately by telephone.
8. An alleged perpetrator will be notified by the program administrator within 3 working days. If an appeal of confirmation is received it will be referred to KDHE Legal Department within 3 working days with supporting documentation.
9. Upon confirmation of the perpetrator, referral will be made to the appropriate licensure/regulatory agency.
10. The program administrator or designee will log all completed report results into the master log and file the report in the facility confidential file.
11. The program administrator is responsible for monitoring compliance within all time frames.
12. A report of complaints received will be forwarded to the Department of Aging monthly.
13. If at any time during the investigation it appears to the surveyor that a criminal offense has been committed, the surveyor is to immediately contact their supervisor. The supervisor will contact the local law enforcement agency if assistance is required. The law enforcement agency should inform KDHE, BACC of what, if any, assistance is being requested of the surveyor.

The supervisor will be responsible for informing the program administrator of any law enforcement agency involvement.

The KDHE investigation is to be completed, but; does not have to be completed prior to referring the report to law enforcement.

TN# MS-92-18 Approval Date AUG 06 1992 Effective Date JUL 01 1992 Supersedes TN# Nothing  
HCFA ID: \_\_\_\_\_

## Adult Abuse, Neglect &amp; Exploitation Reporting &amp; Investigation

## Introduction:

Presently Senate Bill 2800 (KSA 39-1403) mandates the Department of Health and Environment (KDHE) to investigate reports of adult abuse, neglect or exploitation in adult care homes and medical care facilities.

- \* Adult Care Homes (KSA 39-923) - includes any skilled nursing facility, nursing facility, intermediate personal care home, one and two bed adult care homes and any boarding care homes. All adult care homes are required to be licensed by the Secretary of Health & Environment.
- \* Medical Care Facilities (KSA 64-425) - includes any diagnostic and treatment centers or rehabilitation facilities.

## Mandated Reporters:

Statute (KSA 39-1402) identifies those persons required to report suspected abuse, neglect and/or exploitation.

Any person who is licensed to practice any branch of the healing arts including but not limited to: a licensed psychologist, a chief administrative officer of a medical care facility, an adult care home administrator, a licensed social worker, a licensed professional nurse or a licensed practical nurse.

Any person required to report information or cause a report of information to be made who knowingly fails to make such report shall be guilty of a class B misdemeanor.

Any other person having reasonable cause to suspect or believe that a resident is being or has been abused, neglected or exploited may report such information.

## Other Definitions:

- \* "In need of protective services" - a resident unable to perform or obtain services which are necessary to maintain physical and/or mental health.
- \* Caretaker - a person or institution who has assumed the responsibility for the care of the resident voluntarily, by contract or by order of a court of competent jurisdiction.
- \* Services necessary to maintain physical and/or mental health - include but are not limited to: the provision of medical care, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards and maltreatment.
- \* Protective Services - services provided by the state or other government agency or private organization shall include but are not limited to: evaluation of need for services, assistance in obtaining appropriate social services and assistance in securing medical and legal services.

- \* Potential Risk - when a reasonable person would not believe abuse, neglect or exploitation currently exists or occurred, but abuse, neglect or exploitation is likely to occur in the future.
- \* Confirmed - when a reasonable person would conclude that more likely than not abuse, neglect or exploitation occurred.
- \* Unconfirmed - when a reasonable person would conclude that more likely than not abuse, neglect or exploitation had not occurred.
- \* Abuse - Mistreatment of residents/patients as follows:
  - a. Infliction of physical pain or injury - 1) reacting inappropriately to a situation, such as pushing or slapping a resident or 2) intentionally doing bodily harm
  - b. Misuse of chemical or physical restraints to control a resident beyond physicians orders or not in accordance with accepted medical practice - 1) failing to loosen restraints within adequate time frames or 2) utilizing drugs inappropriately while attempting to cope with a resident/patients' behavior.
  - c. Infliction of mental/emotional suffering by verbal/emotional abuse - 1) demeaning statements or 2) harassment, threats, humiliation or intimidation of the resident/patient.
- \* Neglect - Any physical, medical or verbal/emotional neglect as follows:
  - a. Disregard for necessities of daily living such as failure to provide necessary food, clothing, clean linens or provide daily care of the residents/patients' activities of daily living.
  - b. Lack of care for existing medical problems - 1) ignoring a necessary special diet; 2) not calling a physician as necessary; 3) being unaware of medication side effects or 4) not taking action on medical problems.
  - c. Creating situations in which esteem is not fostered - 1) not considering a resident/patients' wishes; 2) restricting contact with family, friends or other residents or 3) ignoring the need for verbal and emotional contact.
- \* Exploitation - intentionally taking unfair advantage of an resident/patients' physical or financial resources for another individuals' personal or financial advantage by use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.
- \* Within twenty-four (24) hours - initial contact will be made in person or by telephone by close of business on the next working day, unless the report indicates the resident/patients' health and/or welfare may be in immediate jeopardy or the resident is in a life threatening situation. If it is determined by the Topeka office that the resident/patient may be in immediate jeopardy or in a life threatening situation the report will be assigned immediately and personal contact will be made within the time frame designated by the Topeka Office.

KANSAS MEDICAID STATE PLAN

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Page 7

OMB No.:

The investigation will be completed within two weeks from the date the report was received in the Topeka office.

Notice of the requirements of this act shall be posted in a conspicuous place in every Kansas adult care home and medical care facility.

TN#MS-92-18 Approval Date Aug 06 1992 Effective Date JUL 01 1992 Superseded TN# Nothing

HCFA ID: \_\_\_\_\_

## I. Receiving Reports

- A. The person taking the report will complete the Form I face sheet. The reporter will then be transferred to the program administrator or designee.
- B. The program administrator or designee will gather as much specific information as possible and determine action based on the following:
- 1) Does the report indicate the resident is in immediate jeopardy or a life threatening situation?
  - 2) Does the report indicate the resident is in eminent danger of harm from the allegation?
  - 3) Does the report indicate the complaint is of a general nature and needs to follow the established KDHE, BACC complaint procedure?

## II. Investigation Process

- A. All reports will be assigned immediately upon receipt or by close of business on the next working day.
1. The report will be relayed to the appropriate regional manager indicating the following:
    - a) Relationship of the reporter to the resident and/or facility
    - b) Nature of report
    - c) Name of facility and address
    - d) Name of the specific resident
  2. The written report with appropriate forms will be forwarded to the appropriate supervisor by close of business on the day received for all Code 1 & 2 investigations. Code 3 investigations will be forwarded to the appropriate supervisor following the regular complaint process.
- B. Investigations will begin within 24 hours following notification of the supervisor and will be completed within 2 weeks from the date received in the Topeka office unless otherwise indicated. Upon completion of the investigation all required forms and necessary information will be received in the Topeka office within 18 days from the time the report was received in the Topeka office.

## III. Completion and Closure of Report

- A. Upon receipt of the investigation report the program administrator will determine what, if any, protective services are needed and make such recommendations to the Kansas Department of Social & Rehabilitation Services (SRS).
- B. SRS will be responsible for providing protective services and a report of action will be submitted to the program administrator within 21 days.
- C. Upon receipt of the protective service report the case will be closed and filed in the facilities confidential file.

- IV. All reports to other agencies or persons will be made by the program administrator. Information regarding the report or the investigation is protected from the public information act and strict confidentiality must be maintained at all times.

(Refer to KDHE complaint policy and procedure and appropriate forms for further instruction regarding deficiency citations)

Revision: HCFA-PM-92-3 (HSQB)  
APRIL 1992

Attachment 4.40-C  
Page 1  
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Procedures for Scheduling and Conduct of Standard Surveys

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The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The Kansas Department of Social and Rehabilitation Services and the Kansas Department of Health and Environment (KDHE) have entered into agreement whereby KDHE schedules and conducts standard surveys. KDHE has in place the following guidelines of survey scheduling and reporting protocol:

Monthly Assignments: KDHE Regional Managers make survey assignments to the generalist and sanitarian surveyors.

Surveyor Work Schedules: Based on survey assignments, surveyors prepare their monthly work schedule and submit it to their Regional Manager.

Unannounced Surveys: Once the assignments have been made, all surveys are required to be unannounced.

Regional Managers Accompanying Surveyors: Periodically, the Regional Manager accompanies surveyors to provide support and help to surveyors and to assure standardization of survey procedure.

Submission of Survey Reports: Health facility surveyors and sanitarians submit completed survey reports to their state regional offices.

Timely Submission of Survey Reports: Survey reports are due at the regional office within seven days after the surveyor completes the survey. Regional offices must also submit survey reports to the central office of KDHE at Topeka within seven days once reports from both the generalist and the sanitarian have been filed.

AUG 06 1992

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TN# MS-92-18 Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Supersedes TN# Nothing  
JUL 01 1992 HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-3 (HSQB)  
APRIL 1992

Attachment 4.40-D  
Page 1  
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Programs to Measure and Reduce Inconsistency

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The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

1. A comprehensive Inservice training program.
2. Interpretive guidelines.
3. A Conflict Prevention Program

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TN# MS-92-18 Approval Date AUG 06 1992 Effective Date MAY 01 1992 Supersedes TN# Nothing  
HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-3 (HSQB)  
APRIL 1992

Attachment 4.40-E  
Page 1  
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Process for Investigations of Complaints and Monitoring

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The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated;  
or
- (iii) the State has reason to question the compliance of the facility with such requirements.

See Attached Pages

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TN# MS-92-18 Approval Date AUG 06 1992 Effective Date JUL 01 1992 Supersedes TN# Nothing  
HCFA ID: \_\_\_\_\_

## DEPARTMENT OF HEALTH AND ENVIRONMENT

## Bureau of Adult &amp; Child Care

Administrative Policy and Procedure

Number:

Date: August 4, 1988

Subject: Complaints

Policy Superseded: February 17, 1986

POLICY STATEMENT

All complaints from any source regarding possible violations of licensing regulations or certification standards shall be received by this agency, assigned for investigation, or if investigated by another agency, received and entered in the record.

PROCEDURE

1. All complaints regarding health facilities shall be referred for receiving in the following order:
  - a. Complaint Coordinator
  - b. Director of Field Services
  - c. Other professional staff.
2. KDHE 110 shall be used to receive all complaints.
  - a. The person receiving a telephone or personal visit complaint shall utilize KDHE 110 for the recording of pertinent information in identifying the issues of a complaint. The receiver should keep in mind that KDHE 110 is used to make the investigation assignment and issues of complaint should relate specifically to possible violation of regulations.
  - b. Written complaints are to be reviewed by the Complaint Coordinator and KDHE 110 completed based on the written complaint received.
3. The Complaint Coordinator or her designee shall assign all KDHE 110 forms and identification numbers per policy and enter the complaints in

Page 2

the master complaint log.

4. The Complaint Coordinator determines the method and assignment of investigation within three working days of receipt. In making assignment, the Complaint Coordinator shall call the appropriate regional manager regarding scheduling and review of the files for complaint history. Issues that are potentially life-threatening or of resident/patient abuse shall be assigned upon receipt to be investigated within 24 hours.
5. KDHE 110 shall be the assignment of investigation document. The completed KDHE 110 and forms KDHE 112 and KDHE 113 shall be forwarded to the appropriate agency or Director of Field Services with necessary supporting documentation attached. If the complaint is filed on an accredited hospital and the alleged violation relates to certification, the Medical Facilities Certification Officer shall contact the Regional Office of the Health Care Financing Administration and advise the Complaint Coordinator on necessary action.
6. The Complaint Coordinator shall correspond with the complainant within three working days confirming the issues of written complaints and plans for resolution unless this has been communicated through the referral agency. The Director of Field Services is responsible to review each complaint before it is sent to the appropriate Regional Manager the assignment for investigation.
7. The investigation shall begin within 15 working days of the request unless otherwise indicated in communication from the Complaint Coordinator.
8. The investigator shall conduct the investigation in the following manner:
  - a. The administrator or person in charge the day of the investigation shall be advised of the complaint investigation and the nature of the complaint. The investigator shall maintain confidentiality of specific details of the complaint, the complainant, and affected resident/patient.
  - b. Investigate techniques used in the

process shall include, but are not limited to, interviews with residents/patients, staff, or others; review of policies and procedures; review of records; survey observation of practices; or any method appropriate to facilitate gathering information.

- c. The investigator shall complete KDHE 112 and narrative report (refer to instruction sheets).
- d. If deficiencies are cited the investigator shall write deficiencies of licensure regulations and/or certification standards identified in the investigation process in accordance with survey procedure.
- e. The investigator shall provide the administrator or person in charge a copy of the statement of deficiencies.
- f. The investigator shall provide the administrator or person in charge a form for including written comments about the investigation. A copy of the comment sheet is left at the facility.
9. KDHE 110, KDHE 112, and KDHE 113 and attachments shall be forwarded to the Regional Manager for review.
10. The Regional Manager shall forward the complete investigation information, including KDHE 110, KDHE 112, and KDHE 113, to Field Services. The Regional Manager shall mail the HCFA-2567 to the facility to request a plan of correction.
11. The Complaint Coordinator shall review the findings and respond to the complainant, facility, Regional Manager, and other parties as required. The Complaint Coordinator shall consult with the Director of Field Services regarding any investigation findings which are unsatisfactory. The Complaint Coordinator shall notify the Medical Facilities Certification Officer of investigation findings which are unsatisfactory for the Hospital Medical Programs Section.

V#MS-92-18 Approval Date AUG 06 1992 Effective Date JUL 01 1992 Superseded TN# Nothing

HCFA ID: \_\_\_\_\_

Unsubstantiated Complaints

1. When the complaint issues are unsubstantiated, the complainant, administrator, and other appropriate persons associated with the complaint shall be advised, in writing, by the Complaint Coordinator within 15 days of determination. The Complaint Coordinator will determine the content of correspondence.
2. For accredited hospitals, a copy of the KDHE 110 and KDHE 112 with attachments shall be forwarded to the Medical Facilities Certification Officer for submittal to the Regional Office.
3. The complaint file shall be closed and placed in the facility's confidential complaint file. The master log shall be completed.

Substantiated Complaints

1. When issues of the complaint are substantiated, the Complaint Coordinator shall notify the Director of Field Services and/or Medical Facilities Certification Officer, as appropriate.
2. When the plan of correction has been received it shall be reviewed by the Complaint Coordinator or designee. The plan of correction shall be approved or returned within three working days. HCFA-2567, HCFA-1539 and scheduled date of follow-up shall be submitted to the Regional Office for XVIII facilities and non-accredited hospitals. The HCFA-2567 shall be submitted to Kansas Department of Social and Rehabilitation Services (SRS) for XIX facilities. The HCFA-562 shall be submitted when required.
3. The Complaint Coordinator shall assign a follow-up date and/or advise the Director of Field Services when a special revisit is needed: a) the follow-up shall be reported on a HCFA-2567B or HCFA-2567; and (b) the follow-up report shall be forwarded to the Regional Office only on XVIII facility complaints. If the follow-up is to occur at the next survey, the results shall be submitted through the normal procedures.
4. When the department has determined action to be taken, the licensee, complainant, Regional Manager, and other persons and/or agencies

associated with the complaint shall be notified as appropriate.

5. When the complaint process is complete as determined by the Complaint Coordinator, all information shall be placed in the facility's confidential complaint file, except that forms HCFA-1539, and comment sheet shall be placed in the licensure files.

6. The master log shall be completed.

#### Investigation Reports from other Agencies

1. Completed investigation reports received from other agencies.
2. The reports are reviewed then entered in the master complaint log and filed in the facility complaint file.

#### Recordkeeping

The Complaint Coordinator is responsible for assigning and maintaining all files and processing information. Complaint files, including the complaint and all records used in processing are to be maintained by the Complaint Coordinator in separate files until the complaint process is completed.

#### Quarterly Report

A quarterly summary of complaints received and processed is to be submitted to the Regional Office within 30 days after each quarter. Copies of the report shall be sent to SRS and Department of Aging.

## KANSAS MEDICAID STATE PLAN

Attachment 4.42-A  
Page 1

Any entity that receives Kansas Medical Assistance Program (KMAP) payments or makes annual payments of \$5,000,000 or more under the KMAP Program must certify that it complies with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

Entities are required to complete and submit a form attesting compliance with Section 6032 of the Deficit Reduction Act to the Kansas Health Policy Authority, annually.

Entities must submit the form attesting their compliance with an effective date of January 1, 2007. For calendar year 2007, this will be due October 1, 2007. In future years, including federal fiscal year 2007, this form must be submitted in the quarter following the end of each federal fiscal year (October to December), but no later than January 1 of the following year.

The Kansas Health Policy Authority and partner agencies have the responsibility to ensure compliance with the requirements. In addition to the annual certification, this will be done through retrospective reviews by the fiscal agent and contractors and other state audits. Entities must be prepared to submit:

- 1) Copies of written or electronic policies that meet the federal requirements;
- 2) A written description of how the policies are made available and disseminated to all employees and to all employees of any contractor agencies for each entity; and
- 3) Copies of any employee handbook, if the entity maintains a handbook, within ten days of the request by the fiscal agent, contractor, or state agency.

APR 30 2007  
TN# 07-03 Approval Date \_\_\_\_\_ Effective Date 01/01/07 Supersedes TN# New

# ATTACHMENTS

ATTACHMENT 5.1-A

Citations of State Laws, Rules, Regulations  
and Policy Statements Providing Assurance  
of Conformity to Federal Merit System Standards

**Citations of State Laws, Rules, Regulations  
and Policy Statements Providing Assurance of Conformity**

The Department of Social and Rehabilitation Services Personnel Administration's regulations are in consonance with the regulations set forth in the "Standards for a Merit System of Personnel Administration" issued by the Department of Health, Education and Welfare, the Department of Labor, and the Department of Defense.

Documentation of the state's merit system and its conformity with Department of Health, Education and Welfare's requirements are filed with federal authorities as part of the approved Public Assistance plan.

774 ?

ATTACHMENT 7.2-A

Methods of Administration - Civil Rights

EQUAL

EMPLOYMENT

OPPORTUNITY

AND

AFFIRMATIVE

ACTION

PLAN

FOR

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

EFFECTIVE DATE July 1, 1983

TN# MS-84-39 Approval Date 2/28/85 Effective Date 10/1/84 Supersedes TN# 80-3

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*ms*  
State Plan TN# 84-29 Effective Date 10/1/84  
Supersedes TN# 80-3 Approval Date 2/28/85

The primary function of S.R.S. is to provide services to  
(Name of Organization)

our clients. To function efficiently on behalf of those we serve, each employee shall accept the personal responsibility for eradicating those biases and prejudices which impede their ability to maximize their efforts in the performance of their primary function(s). Therefore, we shall endeavor to provide services based on relevant criteria. No policy or procedure shall be adopted or implemented which discriminates because of race, religion, color, sex, national origin, ancestry, age, political affiliation or handicap in the offering of services, benefits or employment to any individual.

We shall strive to maintain a workforce which will satisfactorily meet the needs of the persons we serve. Our employees will pledge to diligently perform their jobs, yet being sensitive to the needs of those being served and free from biases and prejudices. All functions whether related to employment or on behalf of those being served shall be performed in a manner that is non-discriminatory. Diligent efforts will be made to maintain a workforce that is representative of the availability standard in this locale with regard to race, sex, age, handicap, etc., in our ongoing efforts as an equal employment opportunity employer. All management--employees shall actively recruit and provide career development--programs to insure equitable representation of minority, female and handicapped persons in all job categories.

The Department of S.R.S. is committed to an affirmative action policy  
(Name of Organization)

which includes an assurance that no discrimination will be tolerated in employment situations which include but are not limited to hiring, promotion, training, transfer, layoff, compensation, physical facilities, or termination.

MS 84-39  
State Plan TN# 803 Effective Date 10/11/84  
Supersedes TNA 803 Effective Date 2/28/85

Mr. Clyde Howard, EEO Administrator under the  
(Name) (Title)

supervision of Dr. Robert C. Harder, Secretary, Department of S.R.S., has been  
(Top-level executive, administrator, or manager)

designated as the Equal Employment Opportunity Representative. In this capacity,  
the EEO Representative is responsible for the implementation, management and  
monitoring of the Affirmative Action Plan and Program.

Duties of the EEO Representative include but are not limited to the following:

- (1) Coordinating EEO related activities within the organization including all branch or satellite facilities.
- (2) providing technical assistance and/or instruction to all employees regarding the organization's Affirmative Action Plan, related laws, and any correlated changes,
- (3) preparing the necessary on-going reports, collecting data, and monitoring the implementation of the Affirmative Action Plan,
- (4) investigating internal complaints, negotiating and resolving EEO related disputes,
- (5) attending training programs designed to enhance knowledge and proficiency in the area of equal opportunity, and
- (6) keeping the Secretary of S.R.S.

(Top-level executive, administrator or manager)

informed of all substantive matters relating to the organization's  
Affirmative Action Plan and Program.

MS 84-39  
State Plan TN# 84-39 Effective Date 10/1/84  
Supersedes TN# 803 Approval Date 2/28/85

On July 1, 1983, an analysis of the present workforce  
 (Date)  
 of Department of S.R.S., was conducted to identify jobs, departments  
 (Name of Organization)  
 and units employing minorities, females, persons between 40 and 70 and those with  
 identified handicaps. The employees included in this analysis are those persons  
 on our payroll as full or part-time employees. A comparison between the workforce  
 and availability standard in this geographical area for handicapped, minority and  
 female employees indicates any underutilization. (Information on workforce  
 population for this location was obtained from the local State Division of Labor/  
 Employment Security Office or State EEO Office. Any underutilization  
 (Source of Information)  
 will be indicated on the underutilization analysis for the goals and timetables, and  
 program analysis section with charts and reported remedial actions to be taken.

MS 84-29  
 State Plan TN# 84-29 Effective Date 10/1/84  
 Supersedes TN# 80-3 Approval Date 2/28/85

WORK FORCE ANALYSIS: HANDICAPPED PERSONS

(1) Department of Social and Rehabilitation Services  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	Total															
	Permanent Authorized Positions (3)	Flo. V (4)	S. V (5)	No. H* (6)	% H* (7)	No. S (8)	% S (9)	No. P (10)	% P (11)	No. L (12)	% L (13)	No. O (14)	% O (15)	Total Handicapped Persons (16)	Handicap Percent (17)	
A	298.2	12	4	7	2			37	12					56	19	
B	2199.8	44	2	41	2			256.5	12			14	1	355.5	16	
C	227.5	2.5	1	3	1			23	10					28.5	12	
D	80.5			2	2			10	12			1	1	13	16	
E	2286	87.5	4	34	1	1	1	409.5	18	3	1	28	1	563	25	
F	1360.5	25.5	2	13	1			187.5	14			8	1	234	17	
G	262.5	2	1	9	3			56	21	1	1	2	1	70	27	
H	1469.5	27	1	20	1	2	1	289	20	1	1	15	1	354	24	

A - Officials/Administrators  
B - Professionals  
C - Technicians  
D - Protective Services  
E - Paraprofessionals  
F - Office/Clerical  
G - Skilled Crafts  
H - Service Maintenance  
V - Visually Handicapped  
H\* - Hearing Handicapped  
S - Speech Handicapped  
P - Physically Handicapped  
L - Learning Handicapped  
O - Other Handicap

NOTE: Vacant permanent authorized positions are recorded in the Work Force Analysis: Sex and Race Chart. These vacancies need not be recorded on this form.

State Plan TN# 770584-39 Effective Date 10/1/84  
Superseded TN# 80-3 Approval Date 2/28/85

GOAL SUMMARY

The Goal Summary, by direction of the State EEO Office, is a figure which includes both the number of protected group persons currently employed by an agency in each EEO category and the number of protected group persons an agency will try to recruit and hire in order to reach parity with the number of protected group persons available.

ms 84-29  
State Plan TN# 84-29 Effective Date 10/1/84  
Supersedes TN# 80-3 Approval Date 2/28/85

GOAL SUMMARY

(1) Central Offices  
State Agency

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	Handicapped Persons (5)
A	58.5	14	14	19	19	
B	138.7	28.5	28.5	47	47	
C	18	2.5	2.5	3.5	3.5	
D	0	0	0	0	0	
E	11.5	9.5	9.5	10	10	
F	214.5	28	28	26.5	26.5	
G	1	1	1	1	1	
H	8	4	4	6	6	

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TN# MS 84-39 Effective Date 10/1/84  
 Supersedes TN# 80-3 Approval Date 2/28/85

GOAL SUMMARY

(1) Institutions \_\_\_\_\_  
State Agency \_\_\_\_\_

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	
A	48	11		19		
B	437.45	96.05		119		
C	79.5	13.75		14		
D	10	12		12		
E	1288.5	555.9		490		
F	402.5	39		73		
G	20	18		57		
H	440	203.5		183		

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TN# ms 84-39 Effective Date 10/1/84  
 Supersedes TN# 86-3 Approval Date 2/28/85

GOAL SUMMARY

(1) Adult Services, SRS  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Handicapped Persons (5)	
A	11	6	3	
B	3.2	2	1	
C				
D				
E				
F	8	2	1	
G				
H				

E - Paraprofessionals  
F - Office/Clerical  
G - Skilled Crafts  
H - Service Maintenance

A - Officials/Administrators  
B - Professionals  
C - Technicians  
D - Protective Services

ms 84-39  
State Plan TN#  
Supersedes TN# 80-3

Effective Date 10/1/84  
Approval Date 2/28/85

GOAL SUMMARY

(1) IM/MS (2) 1984  
State Agency or Organizational Unit Fiscal Year

EE0 Category	EE0 Category Totals: Females (3)	EE0 Category Totals: Minority Persons (4)	EE0 Category Totals: Handicapped Persons (5)
A	15	2	2
B	43	4	3
C			
D			
E			
F	29	3	7
G			
H			

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

Attachment 7.2-A

MS 84-39  
State Plan No. 84-39 Effective Date 10/1/84  
Approved Date 2/28/85

GOAL SUMMARY

(1) SRS, Rehabilitation Services  
 State Agency or Organizational Unit

(2) 1984  
 Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	
A	10	1	1	7		
B	44	8.5	8.5	27		
C	6	.5	.5	.5		
D	N/A	N/A	N/A	N/A		
E	11.5	9.5	9.5	8		
F	59	7	7	2.5		
G	1	1	1	1		
H	6	1	1	6		

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TN# MS 84-39  
 Supersedes TN# 80-3

Effective Date 10/1/80  
 Approval Date 2/28/85

Attach:

GOAL SUMMARY

(1) Administrative Services  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:	
	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A	10.5	2	2	2
B	35.5	9	9	9
C	11	2	2	2
D				
E				1
F	75.5	9	9	7
G	2	1	1	
H				

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

ms 84-29  
State Plan TN# 84-29  
Supersedes TN# 84-3

Effective Date 10/1/84  
Approval Date 2/28/85

GOAL SUMMARY

(1) CAREER SES Management Area  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A	2		1
B	27	1	4
C	1		
D			
E			
F	19.5	2	2
G			
H	27.5	1.5	4

E - Paraprofessionals  
F - Office/Clerical  
G - Skilled Crafts  
H - Service Maintenance

A - Officials/Administrators  
B - Professionals  
C - Technicians  
D - Protective Services

GOAL SUMMARY

(1) Hays Area Office  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A	1		
B	27	2	10
C	1		
D			
E	6.5		4.9
F	34	1	9
G			
H	46	2	21

A - Officials/Administrators  
B - Professionals  
C - Technicians  
D - Protective Services  
E - Paraprofessionals  
F - Office/Clerical  
G - Skilled Crafts  
H - Service Maintenance

Attachment

State Plan TN# MS84-39  
Supersedes TN# 86-3

Effective Date 10/1/84  
Approval Date 2/28/85

GOAL SUMMARY

(1) Hutchinson Area Office  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	
A	1					
L	38	3		6		
C	1					
D						
E						
F	26.5	4.5		2		
G						
H	30	4		9		

L - Paraprofessionals  
F - Office/Clerical  
G - Skilled Crafts  
H - Service Maintenance

A - Officials/Administrators  
B - Professionals  
C - Technicians  
D - Protective Services

ms 84-39  
State Plan TN# 84-39  
Supersedes TN# 80-3

Effective Date 10/1/84  
Approval Date 2/28/85

GOAL SUMMARY

(1) KANSAS CITY AREA OFFICE/SRS (2) 1984  
State Agency or Organizational Unit Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)
A	6	2		5
B	127.5	39		20
C	12.5	4		1.5
D				
E	5	5		2
F	81.5	54		18
G				
H	33.5	34		21

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

Attachment c

State Plan TN# MS 84-39 Effective Date 10/1/84  
 Supersedes TN# 86-3 Approval Date 2/28/85

GOAL SUMMARY

(1) Oswatomie Area  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)
A	2			1
B	35	2		3
C	6.5			
D				
E				
F	21.5	1		3
G				
H	29	2		3

A - Officials/Administrators  
 B - Professionals  
 C - Technicians  
 D - Protective Services  
 E - Paraprofessionals  
 F - Office/Clerical  
 G - Skilled Crafts  
 H - Service Maintenance

State Plan # MS 84-39      Date 10/1/84  
 Supersedes # 86-3      Date 2/28/85

GOAL SUMMARY

(1) Pittsburgh SRS  
State Agency or Organizational Unit

(2) 84  
Fiscal Year

EEO Category	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A	1		
B	24	2	5
C	3		
D			
E			
F	20.5		3
G			
H	23	2.5	6

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

MS84-39  
Supervisor

10/11/84  
3/28/85

GOAL SUMMARY

(1) Salina Area Office  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A	3		
B	35.5	3	6
C	2.5		
D			
E	3		
F	25	2	6
G			
H	38.5	3.5	12

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TN# MS84-39 Effective Date 10/1/84  
Supersedes TN# 86-3 Approval Date 2/25/85

GOAL SUMMARY

(1) Michita Area SRS (2) 1984  
State Agency or Organizational Unit Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	Handicapped Persons (5)
A	7	1			2	
B	129	26			26	
C	11	2.5			3	
D						
E	3	1			1	
F	103	24			20	
G						
H	36	15			8	

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan # MS 84-39 Effective Date 10/1/84  
 Supersedes TR # 86-3 Approval Date 2/28/85

SUMMARY

(1) Kansas Neurological Institute  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:			EEO Category Totals:	
	Females (3)	Minority Persons (4)	Handicapped Persons (5)	Minority Persons (4)	Handicapped Persons (5)
A	7		1		
B	47.5	8	20		
C	28	6	5		
D	2	3	2		
E	197	153	99		
F	30	5	6		
G	2	3	5		
H	64	89	46		

A - Officials/Administrators  
 B - Professionals  
 C - Technicians  
 D - Protective Services

E - Paraprofessionals  
 F - Office/Clerical  
 G - Skilled Crafts  
 H - Service Maintenance

State Plan

MS84-39

10/1/84  
 2/28/85

GOAL SUMMARY

(2) 1981  
Fiscal Year

(1) Wornton State Hospital  
State Agency or Organizational Unit

EEO Category	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A			2
B	15	3	4
C	6	1	1
D	1		
E	90	3	30
F	19		6
G	1		8
H	28	1	19

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TN# MS84-39 Effective Date 10/1/84  
 Supersedes TN# 86-3 Approval Date 2/28/85

GOAL SUMMARY

(1) Parsons State Hospital (2) 1984  
State Agency or Organizational Unit Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	Handicapped Persons (5)
A	5	1	1	3	3	
B	36	6	6	10	10	
C	5	0	0	0	0	
D	0	0	0	0	0	
E	123	26	26	29	29	
F	41	2	2	5	5	
G	2	3	3	5	5	
H	48	14	14	21	21	

E - Paraprofessionals  
 F - Office/Clerical  
 G - Skilled Crafts  
 H - Service Maintenance

A - Officials/Administrators  
 B - Professionals  
 C - Technicians  
 D - Protective Services

Superseded TNA MS84-39 80-3 Approval Date 10/1/84  
7/28/85

GOAL SUMMARY

(1) Topeka State Hospital  
State Agency

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals: Females (3)	EEO Category Totals: Minority Persons (4)	EEO Category Totals: Handicapped Persons (5)
A	10	2	1
B	82.2	7.5	18
C	5.5	.75	2
D	2	3	2
E	16.5	131	52
F	80	17	22
G	2	5	12
H	28.5	28.5	15

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan ENA **MS84-39** Effective Date 10/1/84  
 Superseded ENA 80-3 2/28/85

GOAL SUMMARY

(1) Youth Center at Atchison  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)
A	1			1
B	7	2		1
C				
D				
E	28.5	16		15
F	6.5			
G				2
H	9	1		2

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TN# 81-3 81-3

Effective Date 10/1/84  
Approval Date 2/28/85

GOAL SUMMARY

(1) Youth Center at Topeka  
State Agency or Organizational Unit

(2) 1984  
Fiscal Year

EEO Category	EEO Category Totals:		EEO Category Totals:		EEO Category Totals:	
	Females (3)	Minority Persons (4)	Minority Persons (4)	Handicapped Persons (5)	Handicapped Persons (5)	Handicapped Persons (5)
A	2	3	3	3	3	3
B	12.75	5	5	6	6	6
C	NA	NA	NA	NA	NA	NA
D	0	0	0	0	0	0
E	20	76	76	26	26	26
F	14	1	1	9	9	9
G	1	1	1	5	5	5
H	14	7	7	5	5	5

- A - Officials/Administrators
- B - Professionals
- C - Technicians
- D - Protective Services
- E - Paraprofessionals
- F - Office/Clerical
- G - Skilled Crafts
- H - Service Maintenance

State Plan TNA 11584-39

Supersedes TNA DC 3

10/1/84

2/28/85

ATTACHMENT 7.3

State Governor's Review



OFFICE OF THE GOVERNOR  
State Capitol  
Topeka

ROBERT F. BENNETT  
Governor

June 27, 1977

Dr. Robert C. Harder  
Secretary of Social and  
Rehabilitation Services  
State Office Building, 6th Floor  
Topeka, Kansas 66612

Dear Dr. Harder:

This is to acknowledge that the Office of the Governor has received a copy of the State Plan for Medical Assistance under Title XIX of the Social Security Act.

Thank you for bringing this to my attention.

Very sincerely,

Robert F. Bennett  
Governor of Kansas

RFB:pa

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6/27/77