Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS
Brain Injury (BI)

Updated 06.2025

PART II
HCBS BRAIN INJURY FEE-FOR-SERVICE PROVIDER MANUAL

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FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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INTRODUCTION TO THE HCBS BI WAIVER PROGRAM
Previously known as Traumatic Brain Injury

Updated 08/20

The Home and Community Based Services (HCBS) Brain Injury (BI) waiver is designed to meet the needs of members who have sustained a traumatic, or acquired, or external, or nondegenerative, structural brain injury resulting in residual deficits and disability. The HCBS waivers are designed to prevent institutionalization of members. The variety of services listed below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those members with the desire to live outside of an institution. It is the member's choice to participate in HCBS programs. Services include:

- Assistive Services
- Financial Management Services
  Note: Refer to the *HCBS Financial Management Services Fee-for-Service Provider Manual* for criteria and information.
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation
- Personal Care Services Agency-Directed
- Personal Care Services Self-Directed
- Rehabilitation therapies: Behavior Therapy, Cognitive Rehabilitation, Physical Therapy, Speech-Language Therapy, and Occupational Therapy
- Enhanced Care Services
- Transitional Living Skills

Medicaid waiver services are limited to those services which cannot be procured from other formal or informal resources. Medicaid waiver funds are to be used as the funding source of last resort.

All HCBS BI waiver services require prior authorization through the plan of care (POC) process.

HCBS BI Enrollment

All HCBS BI providers must enroll and receive a provider number for HCBS BI services. Access provider enrollment information on the Provider page of the Kansas Medical Assistance Program (KMAP) website.

Miscellaneous Documentation Requirement

With the transition to an Electronic Verification and Monitoring (EV&M) system through AuthentiCare® Kansas, recoupments are no longer identified solely based on the lack of meeting documentation requirements for dates of service from January 1 to April 30, 2012.

INTRODUCTION TO THE HCBS BI WAIVER PROGRAM

Updated 03/24

BI Waiver Eligibility Determination

1. The Aging and Disability Resource Center (ADRC) shall meet the qualifications specified in the current approved, 1915 (c) HCBS BI waiver.
    a) Functional Eligibility assessors shall meet the qualifications specified in the current, approved, 1915 (c) HCBS BI waiver.
2. Individuals four (4) years of age up to and including 64 years of age, shall submit a functional assessment and medical diagnostic documentation of the brain injury before the BI Program Manager/Program Specialist determines program eligibility for the BI waiver.
    a) Medical diagnostic documentation of the brain injury shall be completed by a qualified medical professional.
    b) If medical diagnostic documentation of the brain injury is not available, the individual applying for waiver services shall submit a Brain Injury Attestation Eligibility Program Form completed by a qualified medical professional.
        i. A BI Program Eligibility Attestation Form can be requested from ADRCs, Managed Care Organizations (MCOs), Kansas Department of Aging and Disability Services (KDADS) BI Program Manager/Program Specialist, KDADS BI Program website, and the KMAP Provider website.
3. Individuals from birth to and including three (3) years of age, before their fourth (4^{th}) birthday, will ONLY be required to provide a medical diagnostic documentation of the brain injury described in 2 (a) or (b) of this section to a Functional Eligibility Assessor.
    a) The document shall be presented to the assessor who will submit it to the HCBS BI Program Manager through a designated state management information system.
    b) Individuals from birth up to and including three (3) years of age, before their fourth (4^{th}) birthday, are only required to complete the demographic section of the Medicaid Functional Eligibility Instrument (MFEI), not the functional assessment.
4. KDADS determines BI waiver program eligibility.
5. The Kansas Department of Health and Environment (KDHE) determines financial and disability eligibility.
6. Failure to provide the medical diagnostic documentation of a qualifying brain injury as defined below, described in 2 (a) and (b) within 14 calendar days of the completed functional assessment will result in a denial.
    a) Individuals determined ineligible due to lacking a qualifying acquired or traumatic brain injury medical documentation may request a second program eligibility review by submitting the documentation to the ADRC, or the KDADS-HCBS BI Program Manager/Program Specialist as outlined in the denial Notice of Action (NOA). The Functional Assessment outcome is good for one year after the date of the Function Assessment.
    b) At the completion of the program eligibility review, those meeting the eligibility criteria will be approved and forwarded to KDHE for Financial and Disability Review.
7. As specified in the HCBS BI waiver, individuals who receive HCBS BI program services must participate in one (1) or more of the offered therapies at least once per month and continue to demonstrate habilitative/rehabilitative progress throughout their duration on the program. Failure to participate in therapies, or to demonstrate rehabilitative progress may result in a transition from, or closure of, the BI waiver.

INTRODUCTION TO THE HCBS BI WAIVER PROGRAM

Updated 03/24

BI Eligibility Criteria

1. Be the age of birth to and including 64 years of age;
2. Be a resident of the state of Kansas;
3. Be financially eligible for Medicaid;
4. Have active habilitation/rehabilitation needs or a brain injury related need for therapies; and
5. Have a documented medical diagnosis of a traumatic or acquired brain injury.
    a) Brain injuries due to a chromosomal or congenital diagnosis do not qualify for the BI waiver.
6. Individuals four (4) years of age up to and including 64 years of age must meet the level of care required for hospital or Brain Injury Rehabilitation Facility (BIRF) placement based on the approved functional eligibility instrument.
    a) Total level of care score of 25 or higher; OR
    b) A minimum score of 26 in the Cognition, Activities of Daily Living (ADL), Instrumental Activity of Daily Living (IADL) and continence areas; OR
    c) A minimum score of 24 in the behavior/emotional and cognition areas.
7. Individuals from birth to and including three (3) years of age, before their fourth (4^{th}) birthday, qualify based ONLY upon the medical documentation signed by a physician indicating a diagnosis of a brain injury not due to a chromosomal or congenital cause.

BI Waiver Eligibility Determination

1. Within five (5) business days of receiving a referral for a functional assessment, the ADRC shall contact the individual and/or the individual's legal guardian and complete an assessment.
    a) The time between when the assessment is referred and performed may exceed five (5) business days at the request of the individual or to meet specific needs of the individual. The request of the individual or specific needs of the individual should be documented.
    b) Where an assessment cannot be completed within five (5) business days after referral, the ADRC will notify KDADS BI Program Manager.
2. The ADRC shall complete the functional assessment face-to-face.
    a) At, or prior to, the time of the functional assessment, the assessor will request medical documentation of BI from the individual.
3. A completed functional eligibility assessment shall include the following documents uploaded and submitted to the BI Program Manager through the designated state management information system by the ADRC:
    a) Medical documentation of the brain injury signed by a qualified medical professional or BI Program Eligibility Attestation Form signed by a qualified medical professional;
    b) Signed Level of Care (LOC) Outcome Form;
    c) Signed Release of Information (ROI) Form;
    d) ES-3160 Notification of KanCare HCBS Services Form (section I and II completed);
    e) Completed Provisional Plan of Care Form showing the BI waiver-related therapy and services the individual is seeking.
4. In the event the medical documentation of the brain injury is not provided prior to or at the time of the functional eligibility assessment, the individual may be offered Administrative Case Management (ACM) to assist the individual in requesting the Brain Injury Attestation Eligibility Program Form to be completed by a qualified medical professional, or to help obtain qualifying medical diagnostic records.

Updated 03/24

BI Waiver Eligibility Determination (continued)

a) In the event the individual chooses not to use ACM, the ADRC shall inform the individual of the 14-calendar-day timeline for submitting the diagnostic documentation to the ADRC to avoid an initial program eligibility review denial.
b) The ADRC shall inform the individual that if the initial program eligibility review is denied, a second program eligibility review may be initiated when the individual submits the diagnostic documentation to either the ADRC or the KDADS Program Manager.
c) The ADRC shall inform the individual that the last phase of eligibility is the financial and disability review completed by KDHE/KanCare after KDADS has determined that program eligibility is satisfied. This review on average can take up to 45 calendar days or more, depending on the complexity of the review.

5. Upon notification from the BI Kansas Assessment Management Information Systems (KAMIS) Workload Report, the BI Program Manager/Program Specialist shall complete the initial review of the functional assessment and supporting documentation uploaded in the current MFEI. If medical diagnostic documentation/BI Program Attestation Form is not available, the review will remain in pending status until the 14th calendar date has passed. At that time the program eligibility will be determined.
    a) KDADS will send a NOA of BI waiver program eligibility determination regarding the outcome of the review to the individual and will send a copy of the 3160 and Physician Plan of Care (PPOC) to KDHE, within two (2) business days from the date of the Program Eligibility Review.

Waitlist Management

If there is a waitlist for the BI waiver, the BI Program Manager shall follow the below process:

1. After the HCBS BI Program Manager has reviewed the functional eligibility assessment and supporting documentation and made an eligibility determination, only individuals who have been found functionally and program eligible may be added to the waitlist.
2. If a waiver offer is sent to an individual on the waitlist, and the individual's functional eligibility assessment is older than 365 calendar days, the BI Program Manager will send a request for the ADRC to complete a functional assessment.

Reassessments

1. The ADRC will conduct annual reassessments of individuals on the BI waiver.
    a) Individuals who have not completed the functional eligibility assessment within 365 days from the date of the requested reinstatement will be required to be re-assessed.
    b) The ADRC will NOT perform a functional reassessment for an individual on the waitlist unless a referral is received from the BI Program Manager.

Documentation Using "Notes" in AuthentiCare Kansas

Providers using AuthentiCare Kansas are expected to use the "notes" field in the AuthentiCare Kansas web application every time adjustments are made (for example, time in/out or activity codes). At a minimum, the following information needs to be included in the note:

- The person requesting the adjustment
- Specifically, what is being adjusted (such as, clock in at 10:35 a.m. added, activity codes for bathing added and toileting removed)

Updated 03/24

Documentation Using "Notes" in AuthentiCare Kansas (continued)

- Reason for the adjustment (such as, started shopping outside of home, forgot to clock in/out)
- If the adjustment was confirmed with the member

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

KMAP Audit Protocols

The KMAP Audit Protocols are available on the Provider page of the KMAP website under the ***Provider Documents*** heading.

HCBS ACCESS FOR INDIVIDUALS IN THE CUSTODY OF DCF

- Access to services will not be available for the purpose of maintenance (including room and board) or supervision required to be provided in a family foster home for individuals who are in the custody of DCF.
- Agency-directed Supportive Home Care is considered the preferred in-home service delivery model for individuals in DCF custody.
- Member direction may be a necessary option for foster children receiving HCBS waiver services who have an identified need yet reside in a geographic area where there is little to no access to agency-directed Supportive Home Care.

PROCEDURES

Member direction for individuals in DCF custody

- Member direction of HCBS waiver services for individuals in DCF custody requires approval of an exception by the Program Manager of the applicable HCBS waiver. An exception may be granted by the Kansas Department for Aging and Disability Services (KDADS) upon consultation with DCF and other applicable authorities. Therefore, the HCBS Program Manager will consult with the DCF Permanency Program Administrator and managed care organization (MCO) prior to approving an exception for member-directed services.

PROCEDURES (continued)

- Approved exceptions for member-directed services may continue as long as there is a documented, identified need. Upon approval of an exception, KDADS will arrange with DCF mutually agreed upon timelines for regularly scheduled review to determine if continuation of an approved exception is warranted.
- Members or other responsible individuals are informed by the member's MCO that when choosing member direction (self-direction) of services, they must exercise responsibility for making choices about Personal Care Services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Members are provided with, at a minimum, the following information about the option to self-direct services:
  - The limitation to Personal Care Services
  - The need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider
    Note: Minor children receiving the exception for member-directed services will not be the employer of record and therefore will not be issued a Federal Employer Identification Number (FEIN). In these cases, the foster care provider contracted by agreement with DCF shall assume all employer-related functions and be considered the employer of record for any workers hired to provide HCBS waiver services for the minor child.
  - The related responsibilities (outlined in I-D)
  - The potential liabilities related to the nonfulfillment of responsibilities in member direction
  - The supports provided by the MCO they have selected
  - The requirements of Personal Care Service providers
  - The ability of the member to choose not to participate in member-direct services at any time
  - Other situations when the MCO may discontinue the member-direct option and recommend agency-directed services
- The MCO is responsible for sharing information with the member about member direction of services. The FMS provider is responsible for sharing more detailed information with the member about member direction of services once the member has chosen this option and identified an enrolled provider. This information is also available from the HCBS Program Manager and KDADS Regional Field Staff.

- Information regarding member-directed services is initially provided by the MCO during the POC/service plan process. During this process, the Member Choice form is completed indicating that the member has chosen HCBS services. The form is signed by the member and included in the POC. This information is reviewed at least annually with the member. The option to end member-direction can be discussed, and the decision to change to agency-directed services can be made once an agency-directed provider is located.

Exceptions concerning the number of nonrelated individuals in DCF custody placed in the same licensed foster home

Note: The statutes and regulations as quoted still reference KDHE as the licensing entity. However, DCF is, in practice, currently responsible for licensing functions.

Updated 08/20

PROCEDURES (continued)

- The KDADS HCBS Program Manager shall review documentation including, but not limited to, the member's POC to determine if placement of the HCBS waiver member in the setting with more than two unrelated children is suitable in meeting the needs of all members. The KDADS HCBS Program Manager shall follow through with providing DCF a documented approval or denial of the exception request.
  Exceptions to the number of individuals that may be placed in the same licensed family foster home is governed by K.A.R. 28-4-804 as administered by KDHE with the cooperation of the DCF. *(Authorized by K.S.A. 65-508 (c) (1); implementing K.S.A. 65-504 and 65-508; effective March 28, 2008.)*
- Each licensee who intends to change the terms of the license, including the maximum number or the age of individuals served, shall submit a request for an amendment on a form supplied by KDHE.
- Any applicant or licensee may request an exception from the Secretary of KDHE. Any request for an exception may be granted if the Secretary determines the exception is in the best interest of a child in foster care and the exception does not violate statutory requirements.
- Written notice from the Secretary stating the nature of the exception and its duration shall be kept on file in the family foster home and shall be readily accessible to KDHE, the child placing agent, the sponsoring child placing agency, DCF, the MCO, and the Kansas Juvenile Services Division of the Kansas Department of Corrections.

Documentation

- Written notification from KDADS to the MCO indicating an approved exception to allow member-directed services for the child in foster care.
- Written notification from KDADS to DCF indicating approval or denial of the exception allowing placement of a waiver member in a foster care setting with two or more unrelated individuals.

7000. HCBS BI BILLING INSTRUCTIONS Updated 01/24

Introduction to the CMS 1500 Claim Form

Providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

Any of the following billing errors may cause a CMS 1500 claim to deny or be sent back to the provider:

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms and Instructions) heading.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

SUBMISSION OF CLAIM

Send completed claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

7010. HCBS BI SPECIFIC BILLING INFORMATION Updated 01/24

ASSISTIVE SERVICES
Enter procedure code **S5165** in Field 24D of the CMS 1500.
One unit equals one purchase.

BEHAVIOR THERAPY
Enter procedure code **H0004** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

COGNITIVE REHABILITATION
For dates of service prior to February 1, 2024, enter procedure code **97129**, **97130** in Field 24D of the CMS 1500.
For dates of service on and after February 1, 2024, enter procedure code **97535** or **97537** in Field 24D of the CMS 1500 form.
One unit equals 15 minutes.

HOME-DELIVERED MEALS
For dates of service prior to October 1, enter diagnosis code **780.99** in Field 21 of the CMS 1500.
For dates of service on and after October 1, enter diagnosis code **R68.89** in Field 21 of the CMS 1500.
Enter procedure code **S5170** (includes preparation per meal) in Field 24D of the CMS 1500.
One unit equals one meal, with a maximum of two meals per calendar date.

MEDICATION REMINDER SERVICES
Medication Reminder (call/alarm) – Enter procedure code **S5185** in Field 24D of the CMS 1500.
One unit equals one month.
Medication Reminder/Dispenser Installation – Enter procedure code **T1505** in Field 24D of the CMS 1500.
One unit equals one installation, limited to one installation per calendar year.
Medication Reminder/Dispenser – Enter procedure code **T1505UB** in Field 24D of the CMS 1500.
One unit equals one calendar month.

OCCUPATIONAL THERAPY
Enter procedure code **G0152** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION
Rental of Personal Emergency Response System – Enter procedure code **S5161** in Field 24D of the CMS 1500.
One unit equals one month.
Installation of Personal Emergency Response System – Enter procedure code **S5160** in Field 24D of the CMS 1500.
Installation is covered up to twice per calendar year.

PERSONAL CARE SERVICES
Personal Care Services Agency-Directed – Enter procedure code **S5125U9** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

PERSONAL CARE SERVICES continued
Personal Care Services Self-Directed – Enter procedure code **S5125UB** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

PHYSICAL THERAPY
Enter procedure code **G0151** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

ENHANCED CARE SERVICES
Enter procedure code **T2025** in Field 24D of the CMS 1500.
One unit equals 6 to 12 hours in any given 24-hour time period.

SPEECH/LANGUAGE THERAPY
Enter procedure code **G0153** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

TRANSITIONAL LIVING SKILLS
Enter procedure code **H2014** in Field 24D of the CMS 1500.
One unit equals 15 minutes.

Note: For billing purposes, the system POC is authorized on a monthly basis. However, the total hours for a member cannot exceed the daily or weekly approved amounts as specified in the Personal Care Services Worksheet, the written POC, and/or the NOA.

Client Obligation
If an MCO care coordinator has assigned a client obligation to a particular provider and informed this provider that they are to collect this portion of the cost of service from the client, the provider will not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Third-Party Liability
KMAP is **secondary payor** to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

- Services for Children and Youth with Special Health Care Needs (CYSHCN) program
- Kansas Department for Children and Families (DCF) Rehabilitation Services
- Indian Health Services
- Crime Victim's Compensation Fund

KMAP is primary to the four programs noted above. Refer to the *General TPL Payment Fee-for-Service Provider Manual* for further guidance on the KMAP public or secure websites.

7010. HCBS BI SPECIFIC BILLING INFORMATION Updated 08/20

Overlapping Dates of Service

- The dates of service on the claim must match the dates approved on the POC and cannot overlap.

  Example An electronic POC has two detail lines items: the first line ends on the 15th of the month and the second line begins on the 16th with an increase of units.

  A claim with a line item for services dated the 8th through the 16th will deny because it conflicts with the dates that have been approved on the electronic POC. At this time, the claims system is unable to read two different lines on the POC for one line on a claim.

  For the first detail line item listed above (up to the 15th of the month), any service dates that fall between the 1st and the 15th of that month will be accepted by the system and not deny because of a conflict in the dates of service.

- Services for multiple months should be separated out, and each month submitted on a separate claim.

Same Day Service

For certain situations, HCBS services approved on a POC and provided the same time a member is hospitalized or in a nursing facility (NF) may be allowed. Situations are limited to:

- HCBS services provided the date of admission, if provided prior to the member being admitted
- HCBS services provided the date of discharge, if provided following the member's discharge
- Personal Emergency Response Systems

Signature Limitations

- In all situations, the expectation is that the member provides oversight and accountability for people providing services for him or her. Signature options are provided in recognition that a member's limitations make it necessary that he or she be assisted in carrying out this function. A designated signatory can be anyone who is aware services were provided. The individual providing the services **cannot** sign the time sheet on behalf of the member.
- Each time sheet must contain the signature of the member or designated signatory verifying that the member received the services and that the time recorded on the time sheet is accurate. The approved signing options include one of the following:
  - Member's signature
  - Member making a distinct mark representing his or her signature
  - Member using his or her signature stamp
  - Designated signatory
- In situations where there is no one to serve as designated signatory, the billing provider establishes, documents, and monitors a plan based on the first three concepts above.
- Members who refuse to sign accurate time sheets without a legitimate reason should be advised that the worker's time may not be paid or money may be taken back. Time sheets that do not reflect time and services accurately should not be signed. Unsigned time sheets are a matter for the billing provider to address with the MCO care coordinator.
- Reimbursement for all HCBS BI waiver services is limited to the member's assessed level of service need and based on the POC. Services must be reimbursed within the approved reimbursement range established by the State.

7020. HCBS BI FINAL RULE MONITORING AND COMPLIANCE Updated 06/24

Effective with dates of service on and after June 1, 2024, KMAP will establish the following compliance requirements of HCBS settings:

- The compliance requirements of providers and settings where individuals participating in HCBS programs receive their support and services.
- The processes and procedures by which the state shall conduct ongoing monitoring activities to ensure continued compliance of HCBS settings with 42 C.F.R. § 441.301(c)(4) and its subparts.

Compliance Requirements for Providers:
The Final Rule's ongoing monitoring and compliance will be assessed based on the following billing codes:

S5101	S5102	S5125	T2016	T2021

New providers enrolling with KMAP to render services under any of the service codes above, and further identified under the provider types and specialties listed below, will need to present verification of HCBS Compliance Portal registration prior to completing the enrollment process:

Provider Type	Provider Specialty	Billing Codes Captured
55	363	S5125, S5126
55	364	T2016
55	365	S5125
55	367	S5125, S5126, S5160, S5161, T2025
55	410	S5101, S5102
55	510	S5125, S5130
55	520	T2020, T2021

Providers will be required to obtain annual certification from the KDADS for each setting where the above codes are billed.

Non-Compliance:

- KDADS will notify the MCO and provider when becoming aware of a non-compliant setting by issuing a corrective action plan (CAP) and indicating a date for the provider/setting to achieve compliance.
- In the event compliance is not achieved by the date set in the CAP, and an HCBS member is active and receiving services from the identified setting, a transition process must be immediately initiated following the KDADS HCBS Transition Policy:
    - Notification will be made by KDADS to the provider, MCO, and KMAP and will include a date that payment for services will no longer be authorized for the member(s) receiving services in the non-compliant setting.
    - KDADS, with the assistance of KDHE, may request a post-payment review and recoup funds from the provider in the event transitions do not occur from non-compliant settings.

7020. HCBS FINAL RULE MONITORING AND COMPLIANCE Updated 06/24

Recertification Criteria:

1. Providers offering services that are not categorized as provider owned, managed, and/or controlled, which may be presumed to be compliant with the Settings Final Rule, shall undergo the presumed compliant screening every 365 days for each service presumed to be compliant.
    a. The provider shall recertify in the event there is a change in service delivery.
    b. A certificate showing the service delivery method is compliant shall be issued.
2. Providers of settings classified as provider owned, managed, and/or controlled, shall complete the HCBS Readiness Assessment for Residential/Day Services, and
    a. Shall re-confirm that no changes have been made to the settings or its immediate surroundings every 365 days after the setting was issued compliance status.
    b. A certificate showing the setting is compliant shall be issued.
    c. If there have been changes to the setting or its immediate surroundings, then the changes may require the setting to complete a new HCBS Readiness Assessment for Residential/Day Services.

Any questions can be directed to KDADS.FINALRULE@ks.gov.

7030. HCBS BI QUALITY ASSURANCE Updated 09/24

HCBS Quality Assurance
Effective August 1, 2024, HCBS Quality Assurance (QA) Policy provides quality assurance oversight for Medicaid 1915(c) HCBS in the State of Kansas. This policy serves as a basis for the State's QA Unit's review of the HCBS Waiver Programs based on HCBS Performance Measures, Program Policies, and Waiver Requirements per waiver type.

Quality Reviews:
KDADS shall conduct quality reviews on Level of Care (LOC) assessments and MCO records for participants receiving HCBS Programs to determine:

- KanCare Quality Performance Measure Outcomes
  - The Performance Measures are included in all current/approved HCBS waivers.
- KDADS HCBS Waiver Program Requirement Outcomes
  - May include, but are not limited to, State Plan requirements and HCBS waiver requirements.

As a condition of Centers for Medicaid and Medicare Services (CMS) waiver approval of each HCBS waiver program, the State of Kansas shall have and comply with defined and approved Quality Assurance (QA) policies and procedures contained in this policy.

- The following sub-assurances of the State's HCBS waiver shall have defined and approved QA requirements:
  - Administrative Authority.
  - Evaluation/Reevaluation LOC.
  - Qualified Providers;
  - Service Plan;
  - Health and Welfare; and
  - Financial Accountability
- KDADS shall conduct QA checks through staff designated as Quality Management Specialists (QMS).
  - KDADS may conduct QA checks through, but not limited to, any of the following methods and data sources:
    - LOC Assessor file reviews
    - MCO file reviews
    - Member's survey feedback
    - Provider's Credentialing, Training, and Background Checks
    - Data found in the following systems:
      a. Kansas Aging Management Information System (KAMIS)
      b. Kansas Modular Medicaid System (KMMS)
      c. Medicaid Management Information System (MMIS)
      d. Quality Review Tracker (QRT)
      e. Kansas Adverse Incident Reporting and Management System (AIRS)

HCBS Quality Assurance continued

Quality Assurance Procedures:

A. KDADS Financial and Information Services Commission (FISC) will select and assign a representative sample of HCBS waiver participants' case files to the QMS Unit for quarterly review.

B. Documentation Required.
   1. Documentation required for each waiver can be found in the **Documentation** section of this bulletin.

C. Authorized Signature
   1. Signatures must be original handwritten, including digital signatures, and dated by the recipient and/or their representative.
      a) A signature on file and/or a signature that converts to a "typed" signature is unacceptable.
      b) If a recipient has a legal guardian, representative, or activated durable power of attorney (DPOA), the legal guardian or DPOA must sign all required document(s).
         i. In the event of representation through a DPOA, supporting documentation showing DPOA activation is required.
         ii. If an electronic signature is used, it must comply with the KDHE KMAP Provider Bulletin Number 782: Electronic Documentation. This policy must be documented to the KDADS HCBS Director, Policy Program Oversight Manager, and QA Manager.
   2. In the event a participant is unable to manually/hand sign their own name due to physical or other limitations, one or more of the following methods may be utilized:
      a) The use of a distinct mark representing the participant's signature;
      b) The use of the participant's signature stamp and/or;
      c) The use of an identified designated signatory.
   3. If a participant utilizes any of the three options in **Quality Assurance Procedures C.2** listed above, documentation supporting the method selected must be uploaded with the QA review.
   4. Each "authorized signature" must be dated.

D. Procedure for conducting quality reviews shall be as follows:
   1. File Reviews:
      a) KDADS shall review documentation uploaded in the Quality Review Tracker (QRT) by the MCOs and/or assessing entities using the established KDADs protocols.
         i. KDADS QMS shall record findings from file reviews in the QRT for the MCO's/assessor's remediation.

E. Record Submission
   1. MCO files are to be uploaded to the QRT database.
   2. LOC assessing entity must upload documents for all HCBS waivers.
      a) LOC Assessment documentation for all HCBS waivers, unless an exception is granted for a specific waiver, may be found in the KAMIS or QRT.

Quality Assurance Procedures continued

3. Case file documentation must be:
   a) Properly labeled with document name and the completion date (month and year); and
   b) Documentation must be legible.
4. At the beginning of each upload period, KDADS will send out specific information regarding documentation that must be uploaded for the audit.
5. When documentation is uploaded to QRT, the MCO/assessing entity must mark the upload as "complete."
6. Documentation uploaded after the deadline will not be considered for the quality review.

F. Deadline for Record Submission
   1. Case files for review shall be listed in the QRT for the review period.
      a) KDADS QA Manager shall notify the MCOs and assessing entity of the required upload.
      b) MCOs and the assessing entity shall have 15 calendar days from upload notification to upload the required documentation.

G. An example of the timeline for a Quality Review is outlined in the following chart:

Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assessing Entity Samples Posted	MCO/Assessing Entity Upload Period (*15 days)	Review of Data (*60 days)
01/01 – 03/31	04/01 – 04/15	04/16	04/16 – 04/30	05/01 – 07-01
04/01 - 06/30	07/01 – 07/15	07/16	07/16 – 07/31	08/01 – 10/01
07/01 – 09/30	10/01 – 10/15	10/16	10/16 – 10/31	11/01 – 01/01
10/01 – 12/31	01/01 – 01/15	01/16	01/16 – 01/31	02/01 – 04/01

H. Findings and Remediation
   1. Protocol Scoring Options:
      a) "Compliant" documentation is provided and meets compliance requirements.
      b) "Non-compliant" documentation was not provided or was not correct or complete.
         i. Missing Document (Document/documentation not provided for review);
         ii. No Valid Signature and/or Date ("Valid signature" means by the individual and/or representative/guardian or Care Coordinator/Case Manager. Must have both signature and date);
         iii. Incomplete (Form was not completed in its entirety);
         iv. Inaccurate (Scoring or eligibility is not correct, or services listed are not being received as outlined in the Person-Centered Service Plan (PCSP), or the process for developing a PCSP was not followed); or
         v. Timeline not met.
      c) "N/A" when not applicable to the protocol question.
   2. Findings from file reviews will be recorded in QRT.

Quality Assurance Procedures continued:

I. Remediation and Response Process
   1. KDADS FISC shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.
   2. CMS requires states to submit remediation language and a Quality Improvement Plan for any HCBS Performance Measure when the statewide average for a waiver is less than 86%. Therefore, KDADS shall complete data analysis to ensure that each quality assurance or sub-assurance of less than 86% is remediated. Further, CMS also requires the state to remediate any "non-compliant internally" (less than 100%) for a performance measure even though it may not be below the 86% threshold requiring the data analysis:
      a) KDADS shall notify the MCO and assessing entity of quality assurance or sub-assurance below 86% with details of each finding.
      b) KDADS shall notify the provider of each non-compliance with a performance measure.
      c) Upon notification of the remediation requirement for quality assurance sub-assurance, or performance measures, providers must respond within 10 business days with a detailed plan for correction/remediation strategies and a timeline for completion.
      d) KDADS staff shall review the received remediation plan for approval. If a remediation plan is not approved, KDADS shall notify the provider and request that acceptable remediation be resubmitted.
      e) Once a remediation plan is approved with a timeline for compliance, KDADS will monitor for compliance.
   3. KDADS shall immediately forward/report Abuse, Neglect, or Exploitation (ANE) issues to the designated state reporting agency.
   4. KDADS FISC shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.
   5. If QMS finds issues or concerns on a specific case during a review:
      a) The issues or concerns shall be entered in QRT.
      b) The QRT system will send an alert to the HCBS Program Manager for the Program Manager's review. Issues that may cause an alert to the HCBS Program Manager include, but are not limited to, the following:
         i. The participant being served could not be located or no longer resides at the address provided in the case record;
         ii. Case should be reviewed for potential closure;
         iii. Assessment is not current;
         iv. Participant being served stated they would like their Care Coordinator to contact them;
         v. There is a protective service concern;
         vi. Spouse cannot serve as a Personal Care Service Worker or in any other paid capacity without a "Spousal Exception;"
         vii. Activated DPOAs/legal guardians are not allowed to provide any direct services without court documentation approving them to do so;
         viii. The assessor is not on the qualified assessor list.

Quality Assurance Procedures continued

J. Quality reviews of credentialing; background checks; provider's training:
   1. Refer to policies posted on the KDADS website at HCBS Policies.
   2. Credentials such as provider specifications applicable to each HCBS waiver, background checks, and training are to be provided per the direction of KDADS.
   3. Provider qualification audit review process per the direction of KDADS and waiver standards.

Documentation:

A. Forms
   1. All forms and templates will be sent to the appropriate assessing entity or MCO at the beginning of the upload period via secure email. Specific required documentation for the audit will be listed in the following documents:
      a) HCBS LOC review: Required documentation for QA Reviews (Frail Elderly (FE), Physical Disability (PD), (BI);
      b) HCBS LOC Review: Required Documentation for QA Reviews (Autism (AU));
      c) HCBS LOC Review: Required Documentation for QA Reviews (Intellectual/Developmental Disability (IDD));
      d) HCBS LOC Review: Required Documentation for QA Reviews (Technology Assisted (TA));
      e) HCBS LOC Review: Required Documentation for QA Reviews (Severe Emotional Disability (SED)
      f) HCBS MCO Record Review: Required Documentation for QA Reviews (Except SED);
      g) HCBS MCO LOC and Record Review: Required Documentation for SED QA Reviews;
      h) QMS' official case review record and findings are in QRT.
   2. Required documentation is subject to change and will be updated on the specific record review document sent out via email at the beginning of every upload period.
   3. For the required documentation, assessing entities/MCOs must provide all current and prior documentation that demonstrates compliance with CFR Regulations, performance measures, applicable policies, and program mandates for every day of the review period.

B. LOC Performance Measure Documentation
   1. The LOC assessing entity is responsible for providing appropriate documentation for this section of the audit review.
   2. Requests for LOC documentation may include, but is not limited to:
      a) Specific waiver eligibility assessment, applicable re-assessments, and any medical documentation if required for eligibility;
      b) Initial Intake/Referral Form;
      c) 3160 approval/Functional Eligibility Assessment request from the specific waiver program manager – if coming off a waitlist or is a crisis/exception, when the initial assessment has expired and will need a new assessment to be eligible for the waiver.

Documentation continued

C. Service Plan and Health and Welfare Performance Measure Documentation
   1. The MCOs are responsible for providing the appropriate documentation for this section of the audit review.
   2. Requests for Service Plan and Health and Welfare Documentation may include, but are not limited to:
      a) 3160 and 3161 – include the initial notification from the eligibility worker of a new member;
      b) PCSP for current and prior PCSP to determine timeliness. The following is considered part of the individual's PCSP and is subject to review:
         i. Documentation of participant choice, as directed by the waiver;
         ii. Physical, Functional, and Behavioral Assessment;
         iii. Back up plan;
         iv. Evidence of information provided on reporting suspected abuse, neglect, and exploitation; and
         v. Goals
      c) Physician/Registered Nurse (RN) Statement (if applicable);
      d) Legal representative, DPOA, and/or guardianship paperwork
      e) Physical exam;
      f) Evidence of rights and responsibilities discussed with participant and/or representative/guardian;
      g) Evidence of appeal and grievance rights/processes discussed with participant and/or representative/guardian;
      h) Notice of Actions (for any updates or changes in Service Plans, including annual reviews and/or adverse actions);
      i) Log or case notes (inclusive of verification of services being received in the type, scope, amount, duration, and frequency specified in the Service Plan);
      j) BI Waiver only - Progress notes for Transitional Living Skills and/or Therapies.
      k) SED Only: Documentation on Critical Incidents/APS/CPS reports regarding restraints, seclusion, or other restrictive interventions and/or anything in the AIR system.

7040. HCBS BI ELECTRONIC VISIT VERIFICATION Updated 01/25

Effective February 6, 2025, AuthentiCare will become the sole approved claims entry point for services that require Electronic Visit Verification (EVV). Initial Claims for EVV covered services that are not received from AuthentiCare will be denied. Claims will be created from AuthentiCare to cover all services, excluding WORK and STEPS that require EVV.

Claims Process

- Claims will be created using the information that comes from MCO and Gainwell FFS (payer) authorizations, caregiver visits, and provider data entry.
- Negotiated rates, up to 12 diagnosis codes, and ordering provider NPI information will be on the claim for the services being provided based on data in the authorization file from payers. Providers will select the appropriate diagnosis pointers for each service line.
- Caregivers will populate the Place of Service (POS) where care takes place when submitting visit information. This will be populated into the claim.

Provider Responsibilities

Before confirming a visit in AuthentiCare to be submitted for claims processing, Provider Administrators will:

- Validate the information contained in the authorization including member, service, start and end dates, diagnosis code, ordering physician, number of approved units, and ensure that service rates are correct. If the claim billed amount is different than the calculated amount, the provider must update with their usual and customary billed amount. The provider is responsible for working with the payer to ensure a proper and accurate authorization is in the AuthentiCare system.
- Validate the visit information submitted by the caregiver.
- Address all critical exceptions found in the rules review process for visits in AuthentiCare by updating the visit information for accuracy, completeness and attesting to the accuracy of the visit information captured.
- Validate the TPL coverage information on the client record is accurate. If not, the provider will need to submit a request for an update through the KMMS provider portal.
- Validate the TPL adjudication information has been correctly entered on the claim for each TPL Payer.
- Validate and attest to the entry of all payor information related to Third Party Liability.
- Provider is responsible for the entry of TPL payments and CARC/RARCs and group codes in AuthentiCare.
- Confirm the visit for billing that will result in AuthentiCare building the claim and submitting it during its daily batch submission process.

Claims Adjustments

Providers may continue to submit claims adjustments through the provider portal. Ensure all required documentation and corrections are submitted timely.

8400. BENEFITS AND LIMITATIONS Updated 02/24

HCBS for persons with a traumatically acquired BI are designed to prevent members from needing to enter or remain in a Brain Injury Rehabilitation Facility (BIRF).

HCBS BI services are available to individuals who are Medicaid-eligible and meet the criteria for institutionalization. The eligible member must meet the following qualifications:

- Be a Kansas resident upon receiving services and for the duration of services.
- Have been diagnosed with an externally caused, traumatically acquired, nondegenerative, structural brain injury resulting in total or partial functional disability and/or psychosocial impairment. Examples of situations where the brain injury may have occurred include:
    - Blow to the head
    - Motor vehicular accident
    - Fall to the ground
    - Physical abuse
    - Violent shaking of the head
- Be at least 16 years of age but less than 65 years of age to receive HCBS BI waiver services. However, if a member receiving waiver services reaches age 65 and is still showing progress in his or her rehabilitation, special consideration may be given by the BI program manager for the member to remain on the waiver past his or her 65th birthday until a time when he or she no longer significantly benefits from Transitional Living Skills and/or rehabilitation therapies. If the member will be age 16 by the time services are due to begin, the assessment may be completed prior to age 16. If a member is 64 years of age at the time of the assessment, they must begin services before the age of 65 to be eligible.
- Shows the capacity to make progress in rehabilitation and independent living skills.
- May require supervision for safety.

Rehabilitation services under the ***Kansas State Plan for Medicaid*** funding are not covered after the sixth month following the date of the first treatment following a physical debilitation resulting from acute physical trauma. Since many patients with brain injury continue to require these services well beyond the seventh month postinjury, and these therapies are necessary to maintain skills learned, they are included in the waiver.

Home health providers are exempt from billing Medicare for services provided to BI waiver recipients if the services are not covered by Medicare or the member does not meet Medicare's definition of homebound services.

Providers may append modifier GY, indicating the service is not covered by Medicare, for HCBS BI waiver service procedure codes listed below if one of the following criteria are met:

- The services provided a not a Medicare-covered service.
- The services do not meet the Medicare-covered criteria.

The following codes can be used with the GY modifier: G0151, G0152, G0153, 97129*, 97130*, 97535*, 97537*, H0004, H2014, S5126 UC, and T2025.

*The BI Waiver will no longer use the code combination of 97129 and 97130 for Cognitive Therapy. Providers may submit either 97535 or 97537 on claims for Cognitive Therapy.

8400. BENEFITS AND LIMITATIONS Updated 02/24

The current limits will still apply and the National Correct Coding Initiative (NCCI) medically unlikely edits (MUE) practitioner (PRA) edits for procedure codes 97535 and 97537 will be deactivated for BI waiver members only. This will allow the cognitive therapy services counted towards the yearly limit of 3,120 units for all BI Waiver therapy services. The BI waiver therapy services are provided with a person-centered approach, adapting to each member's unique needs as outlined in their Person-Centered Plan.

ASSISTIVE SERVICES

Assistive Services is services which meet a member's assessed need by modifying or improving a member's home and through provision of adaptive equipment. Cost-effectiveness should be considered along with other factors, including quality of life and level of independence, when including Assistive Services in a POC.

Purchase or rental of new or used tangible equipment or hardware under the definition of this service is limited to those items not covered through regular Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation or Educational System). This service will be used only as the funding source of last resort. Use of Assistive Services funds requires prior authorization from the BI program manager or other designated KDADS staff.

Assistive Services can include:

- Ramps
- Lifts
- Modifications to bathrooms and kitchens specifically related to accessibility
- Specialized safety adaptations
- Assistive technology that improves mobility or communication
- Shower chairs
- Commodes/walkers

Environmental modifications can only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years and will give first-rent priority to tenants with physical disabilities.

ASSISTIVE SERVICES LIMITATIONS

Reimbursement for this service is one unit equals one purchase. Purchase is limited to a maximum lifetime expenditure of $7,500 per member across waivers. If a member is being served by the BI waiver and assistive services greater than $7,500 are needed, a request may be made to the BI program manager and a determination as to override the limit will be made.

Assistive Services is available, with prior authorization from the BI program manager, to HCBS BI waiver members for situations defined as "critical." Critical situations are defined as and limited to the following:

- A member is returning to the community from an institutional setting such as a NF, BIRF, or other medical facility. The assistive service must be critical to the member's ability to return to and remain in the community and must be a necessary expenditure within the first three months of the member's return to the community.

ASSISTIVE SERVICES LIMITATIONS continued

- A BI waiver member is in a situation where there is one of the following:
    - Confirmation by Adult Protective Services that the member is a recent victim of abuse, neglect, or exploitation
    - Confirmation by Children and Family Services that the member is a recent victim of abuse or neglect
    - Documentation showing that the member is a recent victim of domestic violence

  Note: In each case, the assistive service must be critical to the remediation of the member's abuse, neglect, exploitation, or domestic violence situation; must be a necessary expenditure within three months from the related situation; and must be necessary for the member to remain in the community.

Planning for the use of any assistive service must occur prior to a member's return to the community or other change in living status, when applicable. In all cases, the MCO care coordinator must provide documentation that demonstrates how the assistive service is necessary to remediate the previously described situations.

In accordance with statewide policy and guidelines, all BI waiver members are to be held to the same critical situation criteria when requesting Assistive Services through the BI waiver.

ASSISTIVE SERVICES PROVIDER REQUIREMENTS

Providers of this service include contractors or durable medical equipment (DME) providers. Contractors must be licensed according to the local and county codes where they work. Providers of DME must meet the standards set in KAR 30-5-108. All providers must maintain all standards, certifications, and licenses required for the specific professional field through which the service is provided. All providers must enroll with the State's fiscal agent. However, individually qualified, non-enrolled providers can enter into an agreement with an agency enrolled to provide Assistive Services.

Assistive Services are arranged by the MCO care coordinator with the member's written authorization of the purchase. Members have complete access to choose any qualified provider.

ASSISTIVE SERVICES DOCUMENTATION REQUIREMENTS

Documentation at a minimum must include the following:

- A copy of an invoice or receipt identifying that the service was provided. At a minimum, the receipt must include:
    - Name of business or contractor
    - Technology/service being provided
    - Date of service (month/day/year)
    - Amount of purchase
    - Member's first and last **printed** name and signature
- Statement of inspection by provider to ensure product was purchased/installed as authorized

Documentation must be completed at the time of purchase. Generating documentation after-the-fact is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 08/24

ASSISTIVE SERVICES PLAN OF CARE
Assistive Services must be approved by the BI program manager or other designated KDADS staff. The request should be submitted in writing by the MCO care coordinator and should include the service being requested, the cost of the service, and reason for the request. Supporting documentation such as a catalog price or estimate from a DME provider should also be provided.

UNBUNDLING ASSISTIVE SERVICES FOR HCBS WAIVERS
Effective with dates of service on and after April 1, 2024, and in conjunction with the Kansas Legislature increasing the service limit for Assistive Services prior to the unbundling, Assistive Services will be replaced by three new services with distinct billing codes for the HCBS waivers specified in this policy. These services will be:

Service	Billing Code
Home and Environmental Modification Services (HEMS)	S5165
Vehicle Modification Services (VMS)	T2039
Specialized Medical Equipment and Supplies (SMES)	T2029

This change applies to the following HCBS waivers:
Intellectual and Developmental Disability (I/DD), Brain Injury (BI), FE, and Physical Disability (PD).

Services:
With guidance from the CMS HCBS Technical Guide, the new services unbundled from Assistive Services will be as follows:

Home and Environmental Modification Services, Billing Code S5165
Home and Environmental Modification Services (HEMS) are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence and to create a safer, healthier environment. The need for HEMS adaptations shall be determined through the Person-Centered Service Plan (PCSP) and based on need related to the participant's disability.

This service may be substituted for Personal Services only when they have been identified as a cost-effective alternative to Personal Services on the participant's PCSP. Participants will have access to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs.

This service is limited to those services not covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System). HCBS waiver funding is used as the funding source of last resort and requires prior authorization (PA) from the participant's chosen KanCare MCO.

UNBUNDLING ASSISTIVE SERVICES FOR HCBS WAIVERS continued

Instances

HEMS adaptations may include, but shall not be limited to, the following:

- Modifications to the environment
  - Installation of grab bars.
  - Construction of access ramps and railings.
  - Installation of detectable warnings on walking surfaces.
  - Alerting devices for participant who has a hearing or sight impairment.
  - Adaptations to the electrical, telephone, and lighting systems.
  - Generator to support medical and health devices that require electricity.
  - Widening of doorways and halls.
  - Door openers.
  - Installation of lifts and stair glides (except for elevators), such as overhead lift systems and vertical lifts.
  - Bathroom modifications for accessibility and independence with self-care.
  - Kitchen modifications for accessibility and independence.
  - Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; Plexiglass, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant.
  - Any home modifications not listed here but determined to be of remedial benefit to the participant by a qualified healthcare provider.
- Training on use of HEMS.
- Service and maintenance of the modification.

To determine an economically viable option available to meet a participant's assessed needs, the MCO shall evaluate the most cost-effective HEMS solution by completing a process that includes, but is not limited to, the following:

- Prior to authorizing HEMS, the MCO shall coordinate with other benefits the participant may have, and only use HEMS as a last resort.
  - Waiver funding shall be the funding source of last resort and requires PA from the MCO via the participant's PCSP.
- The MCO shall request an in-home or remote assessment of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments.
  - This helps determine the options available for meeting the participant's needs and which option may be the most cost-effective.
- The MCO will request bids for HEM services.
  - This process will not be completed where the MCO cannot find more than one provider/contractor to provide a bid.
- The MCO will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost.

UNBUNDLING ASSISTIVE SERVICES FOR HCBS WAIVERS continued

- The MCO shall choose the bid that is the most cost-effective and meets the member's needs as it relates to their disability.
- Certain conditions besides cost will determine if a bid is to be accepted.
  - The MCO will not accept bids solely based on the proposed cost.
  - Bids that do not meet the participant's needs or are submitted by contractors with a history of low work quality will not be considered.
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or Financial Management Services (FMS) provider. In that case, the state shall provide a separate provider agreement which will allow the Tribal vendor to receive direct payment from Medicaid

Instructions and Limitations

- Payment for HEMS alone, or in combination with Vehicle Modification Services (VMS) and SMES, shall not exceed $10,000 per program participant and across all waiver programs except the I/DD waiver which does not have a limit. I/DD Waiver participants have no cap on this service.
- If a program participant has exceeded the $10,000 limit, and still has needs that may be furnished through HEMS, the MCO shall furnish such needs using an *'in lieu of other services'* approach, or using other value-added services provided by the MCO.
- Upon delivery to the participant (including installation), the HEMS adaptation must be in good operating condition and repair in accordance with applicable specifications.

Provider Type

1. **Center for Independent Living (CIL)**
   a. Enrolled in KanCare
   b. Certificate of Workers' Compensation and General Liability Insurance
   c. Passing background checks consistent with the KDADS background check policy
   d. Compliance with all laws, policies, and regulations related to abuse, neglect, and exploitation.

2. **Individual Contractor (Non-KanCare Enrolled/Indirect Contractor):**
   a. Affiliation with a CIL
   b. Certificate of Workers' Compensation and General Liability Insurance
   c. Proof of business establishment for a minimum of 2 consecutive years
   d. Passing background checks consistent with the KDADS background check policy
   e. Compliance with all regulations related to abuse, neglect, and exploitation

3. **Individual Contractor (Direct Contractor)**
   a. Enrolled in KanCare
   b. Appropriately licensed in service
   c. Certificate of Workers Compensation and General Liability Insurance
   d. Proof of business establishment for a minimum of 2 consecutive years
   e. Passing background checks consistent with the KDADS background check policy
   f. Compliance with all regulations related to abuse, neglect, and exploitation

UNBUNDLING ASSISTIVE SERVICES FOR HCBS WAIVERS continued

Vehicle Modification Services, Billing Code T2039
In HCBS waivers operated in Kansas, VMS are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle modifications are specified by the PCSP and are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety by removing barriers to transportation.

Reimbursement for this service is limited to the participant's assessed needs related to the participant's disability and based on the PCSP. Participants will have the choice to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs.

This service is limited to those services not covered through the Medicaid State Plan, EPSDT, and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System). HCBS waiver funding is used as the last resort funding source and requires PA from the participant's chosen KanCare MCO.

The State cannot provide assistance with modifications on vehicles that are not registered under the participant or legally responsible parent of a minor or other primary caretaker.

Instances
To determine an economical viable option available to meet a participant's assessed needs based on needs related to disability, the MCO shall evaluate the most cost-effective VMS solution by completing a process that includes, but is not limited to, the following:

- Prior to authorizing VMS, the MCO shall coordinate with other benefits the participant may have and only use VMS as a last resort.
    - Waiver funding shall be the last resort's funding source and requires PA from the MCO via the participant's PCSP.
- If MCO shall request an in-home or remote assessment of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments.
    - This helps determine the options available for meeting the participant's needs; and which option may be the most cost-effective.
- The MCO will request bids for VMS.
    - This process will not be completed where the MCO cannot find more than one provider/contractor to provide a bid.
- The MCO will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost.
- The MCO will proceed to choose the bid that is the most cost-effective and meets the member's needs.
- Certain conditions besides cost will determine if a bid is to be accepted.
    - The MCO will not accept bids solely based on the cost proposed.
    - Bids that do not meet the participant's needs or are submitted by contractors with a low work quality history will not be considered.

UNBUNDLING ASSISTIVE SERVICES FOR HCBS WAIVERS continued

The following are specifically excluded:

- Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
- Purchase or lease of a vehicle; and
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In the case, the state shall provide a separate provider agreement which will allow the Tribal vendor to receive direct payment from Medicaid.

Instructions and Limitations

- Payment for VMS alone, or in combination with HEMS and SMES, shall not exceed $10,000 per program participant and across all waiver programs with the exclusion of the I/DD Waiver participants as there is no cap on this service.
- If a program participant has exceeded the $10,000 limit, and still has needs that may be furnished through VMS, the MCO shall furnish such needs using an *'in lieu of other services'* approach or using other value-added services provided by the MCO.
- Upon delivery to the participant (including installation), the Vehicle Modification must be in good operating condition and repair in accordance with applicable specifications.
  - The State cannot assist with modifications on vehicles that are not registered under the participant or legally responsible parent of a minor or other primary caretaker.

VMS shall include:

- Assessment services to:
  - Help determine specific needs of the participant as a driver or passenger,
  - Review modification options, and
  - Development of a prescription for required modifications of a vehicle.
- Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent/guardian of a minor or other caregiver as approved by KDADS Program Manager.
- Non-warranty vehicle modification repairs.
- Training on use of the modification.

The following as specifically excluded from VMS:

- Purchase or lease of new or used vehicles
- General vehicle maintenance or repair, except upkeep and maintenance of the modifications.
- If a program participant has exceeded the $10,000 limit, and still has needs that may be furnished through VMS, the MCO shall furnish such needs using an *'in lieu of other services'* approach, or using other value-added services provided by the MCO.
- Upon delivery to the participant (including installation), the Vehicle Modification must be in good operating condition and repair in accordance with applicable specifications.
  - The State cannot assist with modifications on vehicles that are not registered under the participant or legally responsible parent of a minor or other primary caretaker.

UNBUNDLING ASSISTIVE SERVICES FOR HCBS WAIVERS continued

- State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.
- Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual.

Provider Type

1. **Center for Independent Living (CIL)**
    a. Enrolled in KanCare
    b. Certificate of Workers' Compensation and General Liability Insurance
    c. Passing background checks consistent with the KDADS background check policy
    d. Compliance with all regulations related to abuse, neglect, and exploitation.

2. **Individual Contractor (Non-KanCare Enrolled/Indirect Contractor):** This entity will subcontract with a CIL which shall perform the background checks.
    a. Affiliation with a CIL
    b. Certificate of Workers Compensation and General Liability Insurance
    c. Proof of business establishment for a minimum of 2 consecutive years
    d. Passing background checks consistent with the KDADS background check policy
    e. Compliance with all laws, policies, and regulations related to abuse, neglect, and exploitation.

3. **Individual Contractor (Direct Contractor)**
    a. Enrolled in KanCare
    b. Appropriately licensed in service
    c. Certificate of Workers Compensation and General Liability Insurance
    d. Proof of business establishment for a minimum of 2 consecutive years
    e. Passing background checks consistent with the KDADS background check policy
    f. Compliance with all laws, policies, and regulations related to abuse, neglect, and exploitation.

Specialized Medical Equipment and Supplies, Billing Code T2029

In HCBS waivers operated in the State of Kansas, SMES include: (a) devices, controls, or appliances, specified in the PCSP, that enable participants to increase their ability to perform ADL; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant's needs.

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

Instances

Some instances where SMES may be used include, but are not limited to, the following:

- A program participant may use SMES service to supplement DME furnished through the State plan, such as wheelchairs or walkers.
- A program participant may use SMES to purchase disposable non-durable equipment or supplies such as wipes or testing strips.
- A program participant may also access augmentative communication devices and services through SMES.

Instructions and Limitations

- The program participant's person-centered planning team shall assess them for their need for SMES. This service supports the achievement of the outcomes as specified in the program participant's PCSP.
- The MCO will access the State plan to cover medical supplies and equipment the state of Kansas has made available under the State plan under DME.
- To avoid overlap of services, this service is limited to those services not covered through the Medicaid State Plan, EPSDT, or other HCBS services and which cannot be procured from other formal or informal resources.
- Payment for SMES alone, or in combination with HEMS and VMS, shall not exceed $10,000 per program participant and across all waiver programs except for the I/DD waiver as there is no limit on these services.
- If a program participant has exceeded the $10,000 limit, and still has needs that may be furnished through SMES, the MCO shall furnish such needs using an *'in lieu of other services'* approach, or using other value-added services provided by the MCO.
- The coverage/provision of SMES furnished through this service shall include the costs of maintenance and upkeep of devices and training on the utilization of the devices. This includes normal wear and tear. Intentional destruction or damage to devices will not be a covered cost.
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In this case, the state shall provide a separate provider agreement which will allow the Tribal vendor to receive direct payment from Medicaid.
- HCBS waiver funding shall be the funding source of last resort and requires PA from the MCO via the participant's PCSP.

Provider Type:

1. **Center for Independent Living (CIL)**
    a. Enrolled in KanCare
    b. Certificate of Workers' Compensation and General Liability Insurance
    c. Passing background checks consistent with the KDADS background check policy
    d. Compliance with all laws, policies, and regulations related to abuse, neglect, and exploitation.

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

2. **Individual Contractor (Non-KanCare Enrolled/Indirect Contractor)** This entity will subcontract with a CIL, with CIL to perform the background check.
    a. Affiliation with a CIL
    b. Certificate of Workers' Compensation and General Liability Insurance
    c. Proof of business establishment for a minimum of 2 consecutive years
    d. Passing background checks consistent with the KDADS background check policy
    e. Compliance with all regulations related to abuse, neglect, and exploitation.

3. **Individual Contractor (Direct Contractor)**
    a. Enrolled in KanCare
    b. Appropriately licensed in service
    c. Certificate of Workers' Compensation and General Liability Insurance
    d. Proof of business establishment for a minimum of 2 consecutive years
    e. Passing background checks consistent with the KDADS background check policy
    f. Compliance with all regulations related to abuse, neglect, and exploitation

8400. BENEFITS AND LIMITATIONS Updated 08/20

BEHAVIOR THERAPY

In general, Behavior Therapy applies to the application of findings from behavioral science research to help individuals change in ways that they would like to change. These research-based strategies are used to help increase the quality of life of the individual with BI and decrease problem, self-destructive behavior, such as aggression, property destruction, self-injury, poor anger management, and other behaviors that can interfere with an individual's ability to adapt to and live successfully in the community. Behavior Therapy can involve looking at the individual's early life experiences, long-time internal psychological or emotional conflicts, and/or the individual's personality structure. Generally, however, Behavior Therapy emphasizes the individual's current environment. It focuses on making positive changes in that environment while improving the individual's self-control using procedures to expand the person's skills, abilities, and level of independence.

BEHAVIOR THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per member, per calendar year, for any combination of the following HCBS BI therapies: behavior, cognitive, occupational, physical, and speech/language.

Behavior Therapy is to be provided according to the member's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the member continues to make progress in his or her rehabilitation.

BEHAVIOR THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Members' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Members' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Member's first and last name
- Date of service (month/day/year)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

BEHAVIOR THERAPY DOCUMENTATION continued
Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

BEHAVIOR THERAPY PROVIDER REQUIREMENTS
Behavior Therapy must be provided by individuals who are either:

- Licensed by the Kansas Behavioral Sciences Regulatory Board
  OR
- Certified in Special Education by the Kansas State Department of Education

Other qualifications include:

- Master's degree in a behavioral science field, such as psychology or social work
  OR
- Master's degree in Special Education
  AND
- 40 hours of training in BI
  OR
- One year of experience working with individuals with BI

Behavior Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

COGNITIVE REHABILITATION
Cognitive Rehabilitation is a treatment process in which a person works to alleviate deficits in thinking. In cases of persons with BI, these deficits can include poor attention and concentration, memory loss, difficulty with problem solving, and dysfunctional thoughts and beliefs that can contribute to maladaptive behavior and emotional responses. Through Cognitive Rehabilitation, the individual utilizes methods that aim to help make the most of existing cognitive functioning despite the difficulties they are experiencing through various methods, including guided practice on tasks that reflect particular cognitive functions, development of skills to help identify distorted beliefs and thought patterns, and strategies for taking in new information, such as the use of memory aids and other assistive devices. The goal for individuals receiving Cognitive Rehabilitation is to achieve an awareness of their cognitive limitations, strengths, and needs and acquire the awareness and skills in the use of functional compensations necessary to increase the quality of life and enhance their ability to live successfully in the community.

COGNITIVE REHABILITATION LIMITATIONS
There is a limitation of 3120 units (one unit equals 15 minutes) per member, per calendar year, for any combination of the following HCBS BI therapies: behavior, cognitive, occupational, physical, and speech/language.

COGNITIVE REHABILITATION LIMITATIONS continued
Cognitive Rehabilitation is to be provided according to the member's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the member continues to make progress in his or her rehabilitation.

COGNITIVE REHABILITATION DOCUMENTATION
Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Members' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Members' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Member's first and last name
- Date of service (month/day/year)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

COGNITIVE REHABILITATION PROVIDER REQUIREMENTS
Cognitive Rehabilitation must be provided by individuals who are either:

- Licensed by the Kansas Behavioral Sciences Regulatory Board
  OR
- Certified in Special Education by the Kansas State Department of Education

Other qualifications include:

- Master's degree in a behavioral science field, such as psychology or social work
  OR
- Master's degree in Special Education
  AND
- 40 hours of training in BI
  OR
- One year of experience working with individuals with BI

COGNITIVE REHABILITATION PROVIDER REQUIREMENTS continued

Cognitive Rehabilitation can be provided by an individual under the supervision of the enrolled, qualified provider.

HOME-DELIVERED MEALS

Home-Delivered Meals provides a member with one or two meals per calendar date. Each meal must contain at least one-third of the recommended daily nutritional requirements. The meals are prepared elsewhere and delivered to the member's home. Members eligible for this service have been determined functionally in need of Home-Delivered Meals as indicated by the Uniform Assessment Instrument/Long Term Care (LTC) Threshold score. Meal preparation provided by HCBS BI Personal Care Services providers may be authorized in the member's POC for those meals not provided under Home-Delivered Meals.

HOME-DELIVERED MEALS LIMITATIONS

- Providers of Home-Delivered Meals must have on staff or contract with a certified dietician to ensure compliance with KDADS nutrition requirements for programs under the Older Americans Act.
- This service is limited to members who require extensive routine physical support for meal preparation as supported by the member's Uniform Assessment Instrument/LTC Threshold Score for meal preparation.
- This service may NOT be maintained when a member is admitted to a NF or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.
- This service is not to be duplicative of the home-delivered meal service provided through the Older Americans Act, subject to the member meeting related age and other eligibility requirements.
- This service is available in the member's home.
- No more than two home-delivered meals will be authorized per member for any given calendar date.
- This service must be authorized in the member’s POC.

HOME-DELIVERED MEALS DOCUMENTATION

Proof of meal delivery is required to verify that the member received the meal(s). Home-Delivered Meals providers are required to maintain proof of delivery and have related documentation available upon request.

If providers use direct delivery to the member, proof of delivery documentation must include the following information:

- Service provider’s name
- Description of the service provided
- Date of service (month/day/year)
- Member’s name
- Cost of the service

HOME-DELIVERED MEALS DOCUMENTATION continued
If the Home-Delivered Meals provider uses a shipping service or mail order, proof of delivery could include the service's tracking document and the provider's own shipping invoice or summary report. If possible, the provider's records should also include the delivery service's ID number for the item sent to the member. The shipping service's tracking document should reference each individual delivery item, the delivery address, the corresponding ID number given by the shipping service, and the date delivered, if possible.

Documentation must be created during the time frame of the billing cycle. Generating documentation after-the-fact is not acceptable. Documentation must be clearly written and self-explanatory or reimbursement may be subject to recoupment.

HOME-DELIVERED MEALS PROVIDER REQUIREMENTS
Providers of Home-Delivered Meals must have on staff or contract with a certified dietician to ensure compliance with KDADS nutrition requirements for programs under the Older Americans Act.

MEDICATION REMINDER SERVICES
Medication Reminder Services provides a member with a scheduled reminder for when it is time to take medications. Medication Reminder Services includes three distinct services:

- Medication Reminder is a scheduled phone call, automated recording, or automated alarm, depending on the provider's system.
- Medication Reminder/Dispenser is a device that stores a member's medication and dispenses the medication with an alarm at programmed times.
- Medication Reminder/Dispenser Installation is the placement of the medication dispenser in a member's home.

Education and assistance with Medication Reminder Services is made available to members during implementation and as needed after implementation by the provider of this service.

MEDICATION REMINDER SERVICES LIMITATIONS

- The maintenance of rental equipment is the provider's responsibility.
- Repair or replacement of rental equipment is not covered.
- Rental of equipment is covered.
- Purchase of equipment is not covered.
- This service is limited to members who live alone or who are alone a significant portion of the day and have no regular informal and/or formal support for extended periods of time and who otherwise require extensive routine nonphysical support including medication reminder services offered through a personal care services worker of Personal Care Services.
- This service is not duplicative of any free services offered through any other agency or service.
- These systems may be maintained on a monthly rental basis even if a member is admitted to a NF or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.
- This service is available in the member's home.

MEDICATION REMINDER SERVICES LIMITATIONS continued

- Medication Reminder Services is not provided face-to-face with the exception of the installation of the medication reminder dispenser.
- Installation of the medication reminder dispenser is limited to one installation per member per calendar year.

MEDICATION REMINDER SERVICES DOCUMENTATION

Documentation must include the following:

- Service provider's name
- Service being provided
- Date of service (month and year)
- Member's first and last name
- Cost of service

Documentation must be created during the time frame of the billing cycle. Generating documentation after-the-fact is not acceptable. Documentation must be clearly written and self-explanatory or reimbursement may be subject to recoupment.

MEDICATION REMINDER SERVICES PROVIDER REQUIREMENTS

Any company providing medication reminder services and dispenser installation per industry standards is eligible to enroll as a Medicaid provider of Medication Reminder Services. Providers must also conform to any federal, state, and local laws and regulations that govern this service.

MEDICATION REMINDER SERVICES REIMBURSEMENT

Reimbursement for this service is one unit equals one month. For installation, one unit equals one installation of the medication reminder dispenser and is limited to one installation per calendar year. For the monthly device fee, one unit equals one calendar month.

Note: The requirement for providers to use AuthentiCare to bill for the referenced procedure code/ service code has been eliminated. This is a limited service codes that no longer require providers to bill through AuthentiCare. Providers may bill through AuthentiCare or to the MCO directly.

OCCUPATIONAL THERAPY

Occupational Therapy is a treatment approach that focuses on the effects of injury on the social, emotional, and physiological condition of the individual, and evaluates an individual's balance, motor skills, posture, and perceptual and cognitive abilities within the context of functional, everyday activities. Occupational Therapy helps individuals with BI achieve greater independence in their lives by regaining some or all the physical, perceptual, and/or cognitive skills needed to perform activities of daily living through exercises and other related activities. When skills and strength cannot be adequately developed or improved, Occupational Therapy offers creative solutions and alternatives for carrying out daily activities. This is done by manipulating the individual's environment or by obtaining or designing special adaptive equipment and training the individual in its use. In every case, the goal of Occupational Therapy is to help people develop the living skills necessary to increase independence and, thus, enhance self-satisfaction with the person's quality of life.

OCCUPATIONAL THERAPY continued

Occupational Therapy waiver services are provided when the limits of the approved Occupational Therapy State Plan service (for example, up to six months postinjury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the ***Kansas State Plan for Medicaid*** are provided according to the member's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the member continues to make progress in his or her rehabilitation.

OCCUPATIONAL THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per member, per calendar year, for any combination of HCBS BI therapies: behavior, cognitive, occupational, physical, and speech/language.

OCCUPATIONAL THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Members' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Members' files may be used for supervisory reviews, HCBS Special Service Team (HSST) reviews, quality assurance review, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Member's first and last name
- Date of service (month/day/year)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

Supervision of an individual working under the enrolled occupational therapist must be clearly documented. This may include, but is not limited to, the therapist initializing each treatment note written by the individual working under the therapist.

Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

OCCUPATIONAL THERAPY PROVIDER REQUIREMENTS

Occupational Therapy must be provided by individuals who:

- Are licensed by the Kansas Board of Healing Arts (K.S.A. 65-5401 et seq)
  AND
- Have 40 hours of training in BI or one year of experience working with individuals with BI.

Occupational Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION

Personal Emergency Response System (PERS) is an electronic device which enables certain members at high risk of institutionalization to secure help in an emergency. The member can also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center once the "help" button is activated.

The MCO care coordinator authorizes the need for this service based on an underlying medical or functional impairment.

Once installed, these systems can be maintained on a monthly rental basis even if the member is admitted to a NF or acute care facility for a planned brief stay period not to exceed the month of admission and the following two months in accordance with public assistance policy.

PERSONAL EMERGENCY RESPONSE SYSTEM LIMITATIONS

Limitations to PERS services include the following:

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of equipment is not covered.
- Rental, but not purchase, of this service is covered.
- Call lights do not meet this definition.
- Maximum of two PERS installations per year.
- This service is limited to those members who live alone, or who are alone for parts of the day, and have no regular caregiver for extended periods of time.

PERSONAL EMERGENCY RESPONSE SYSTEM PROVIDER REQUIREMENTS

Any company providing Personal Emergency Response System and installation services is qualified to provide this service. Provider requirements include:

- Must be a Medicaid-enrolled provider
- Must conform to industry standards and any federal, state, and local laws and regulations that govern this service

Note: The emergency response center must be staffed on a 24-hour/7-days-a-week basis by trained personnel.

PERSONAL EMERGENCY RESPONSE SYSTEM DOCUMENTATION

Documentation **at a minimum** must include **the following**:

- Service provider's name
- Service being provided

PERSONAL EMERGENCY RESPONSE SYSTEM DOCUMENTATION continued

- Date of service (month and year)
- Member's first and last name
- Cost of service

Documentation must be created during the time frame of the billing cycle. Generating documentation after-the-fact is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

PERSONAL CARE SERVICES (AGENCY-DIRECTED AND SELF-DIRECTED)

Personal Care Services means assistance provided to a person with a disability with tasks that the person would typically do for himself or herself in the absence of his or her disability. Such services may include, but are not limited to, bathing, grooming, toileting, dressing, transferring, eating, mobility, housecleaning, meal preparation, laundry, shopping, and any other service that is considered an Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL). Services are associated with normal rhythms of the day that can occur both in the person's home and in the greater community. This includes transportation to and from related activities (although only the time involved with transportation and not transportation costs is included in the scope of Personal Care Services).

Health maintenance activities, such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, and range of motion, may be provided as Personal Care Services when they are delegated by a physician or licensed professional nurse and are documented in the POC, in accordance with K.S.A. 65-6201.

Personal Care Services may be provided as a self-directed or agency-directed service:

- With Personal Care Services Self-Directed, members hire, train, and supervise their personal care services workers. FMS providers are responsible for payroll-related activities and for providing information and assistance to members to ensure that they understand the responsibilities involved with the self-direction of their Personal Care Services. (Refer to the *HCBS FMS Fee-for-Service Provider Manual* for more information.)
- With Personal Care Services Agency-Directed, a qualified agency that meets all the related enrollment requirements manages all aspects of Personal Care Services.

PERSONAL CARE SERVICES LIMITATIONS

Medicaid non-waivered home health aide services for HCBS BI members require prior authorization. No more than one personal care services worker can be paid for services at any given time of the day nor is a personal care services worker to work with more than one member at the same time and date. Exceptions must be justified and documented by the MCO care coordinator, such as two-person lift for safety issues. The HCBS BI program manager must give approval for these services.

A Medicaid member is eligible only for the number of hours per day or per week as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved hours for a member cannot exceed either the daily approved number of hours or weekly approved number of hours.

PERSONAL CARE SERVICES LIMITATIONS continued

Personal Care Services are available to HCBS BI waiver members up to a maximum of 12 hours per 24-hour time-period. Personal Care Services requests exceeding 12 hours per 24-hour time-period require prior authorization from the BI program manager based on one or more of the following critical situations:

- The member is returning to the community from an institutional setting such as a NF, BIRF, or other medical facility. Personal Care Services exceeding 10 hours per 24-hour time period must be critical to the member's ability to return to and remain in the community.
- A BI waiver member is in a situation where there is one of the following:
    - Confirmation by Adult Protective Services that the member is a recent victim of abuse, neglect, or exploitation
    - Confirmation by Children and Family Services that the member is a recent victim of abuse or neglect
    - Documentation showing that the member is a recent victim of domestic violence

  Note: In each case, Personal Care Services must be critical to the remediation of the member's abuse, neglect, exploitation, or domestic violence situation and be necessary for the member to remain in the community.
- A BI waiver member has a documented health and safety need that requires more than a total of 10 hours per 24-hour period. Related needs include two-person transfers, certain medical interventions, or supervision for elopement that is likely to result in danger to the member or others.

Planning for the use of Personal Care Services must occur prior to a member's return to the community or other change in living status, when applicable. In all cases, the MCO care coordinator must provide documentation demonstrating how Personal Care Services hours that exceed the 10-hour limit are necessary to remediate the previously described situations.

In accordance with statewide policy and guidelines, all BI waiver members are to be held to the same critical situation criteria when requesting to exceed the 10-hour limit on Personal Care Services through the BI waiver.

PERSONAL CARE SERVICES REIMBURSEMENT

A Medicaid member is eligible only for the number of hours per day or per week as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved hours for a member cannot exceed either the daily approved number of hours or weekly approved number of hours.

All Personal Care Services will be reimbursed to and paid to the attendant through an enrolled home health agency when services are agency-directed or an enrolled FMS provider when services are self-directed.

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PERSONAL CARE SERVICES DOCUMENTATION
Documentation is required for services provided and billed to KMAP. Documentation must be legible and self-explanatory, or reimbursement may be subject to recoupment.

The provision of self-directed Personal Care Services must be documented by using AuthentiCare Kansas and its Interactive Voice Response (IVR) system. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided
- Identification of the member receiving the service (first and last name)
- Identification of the personal care services worker providing the tasks
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

For agency-directed Personal Care Services and those limited instances where the self-directing member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided
- Member's printed name (first and last) and signature on each page of documentation (see Signature Limitations)
- Personal care services worker's printed name and signature on each page of documentation
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable.

PERSONAL CARE SERVICES PROVIDER REQUIREMENTS
Support staff must be at least 18 years of age and have training as recommended by the member, guardian/representative (if applicable), or medical provider. An adult member's spouse or a minor member's parents must not be paid to provide this service unless granted an exception by the BI program manager as outlined in K.A.R. 30-5-307. Any other persons who are directing or coordinating care on behalf of a member may not provide Personal Care Services to that same member. Agencies providing Personal Care Services must be licensed home health agencies and enroll with the State's fiscal agent. Individual, non-enrolled providers of Personal Care Services must enter into an agreement with an enrolled provider of FMS.

Medicaid providers who wish to provide payroll agent services to self-directed members should review the Medicaid provider manual for HCBS FMS.

Any entity enrolled to provide Personal Care Services or serving as an FMS provider for individuals who self-direct their Personal Care Services must maintain a current listing of the name, address, and telephone number of all providers rendering these services.

Any entity required to maintain a current list of the name, address, and telephone number of personal care services persons will, upon request, make such information available to federal and state agencies, law enforcement, the attorney general's office, and legislative post audit. If there is a dispute between the provider and a requesting entity on whether the list should be released, the state agency responsible for the program will make the final decision.

PERSONAL CARE SERVICES (PCS) IN ACUTE CARE HOSPITAL SETTINGS

Effective July 1, 2024, Personal Care Services (PCS) may be delivered in an acute care hospital setting under specific conditions. This change is designed to ensure continuity of essential non-medical supports for participants during short-term hospital stays, especially for individuals with behavioral, communication, or functional support needs that may not be fully addressed by hospital staff.

Conditions for PCS Delivery in Hospital Settings:

PCS may be delivered during a participant's hospital stay when the following conditions are met:

- **Support with ADLs/IADLs**: Services are necessary to assist with the participant's Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) during the hospital stay.
- **Non-duplication of Hospital Services:** PCS must not duplicate hospital services already provided under standard care (e.g., nursing, bathing, mobility assistance).
- **Person-Centered Planning:** When feasible, the participant's Person-Centered Service Plan (PCSP) should document the need for PCS during hospitalization, especially for participants with recurring hospitalizations or unmet support needs.
- **Clinical Review and Coordination:** Managed Care Organizations (MCOs) should use clinical judgment, in consultation with the provider and PCSP, to determine the appropriateness of PCS.

Authorization and Provider Requirements:

- Services must be authorized by the MCO.
- Services must be delivered by a waiver-approved PCS provider.
- All services must adhere to waiver-specific guidelines and must align with the participant's approved PCSP.

PERSONAL CARE SERVICES (PCS) IN ACUTE CARE HOSPITAL SETTINGS continued

Documentation and Claims Submission Requirements:

- Services must align with the participant's PCSP.
- All services must be documented in the Electronic Visit Verification (EVV) system, including time in/time out and service location.
- Use Place of Service (POS) code 21 for hospital-based PCS.

Applicable Procedure Codes:

Service	KMAP Codes
Personal Care Services	S5125 U9, S5125 UB (Self-directed)

PHYSICAL THERAPY

Physical Therapy is a treatment approach that assists persons with reaching their highest level of motor functioning and mobility. Through Physical Therapy, people with BI are assessed and receive treatment to move and perform functional activities in their daily lives and to help prevent conditions associated with loss of mobility through fitness and wellness programs that achieve healthy and active lifestyles. Treatment may involve intensive work in a variety of areas including standing, sitting, walking, balance, muscle tone, endurance, strength, and coordination. Physical Therapy also identifies and instructs the individual in the use of special equipment, when necessary, that can help the individual adapt to limited physical functioning and move more freely and independently in his or her environment.

Physical Therapy waiver services are provided when the limits of the approved Physical Therapy State Plan service (for example, up to six months postinjury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the ***Kansas State Plan for Medicaid*** are provided according to the member's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the member continues to make progress in his or her rehabilitation.

PHYSICAL THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per member, per calendar year, for any combination of the following HCBS BI therapies: behavior, cognitive, occupational, physical, and speech/language.

PHYSICAL THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Members' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Members' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

PHYSICAL THERAPY DOCUMENTATION continued

Each visit must be documented. Documentation must include:

- Service being provided
- Member's first and last name
- Date of service (month/day/year)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

Supervision of an individual working under the enrolled physical therapist must be clearly documented. This may include, but is not limited to, the therapist initializing each treatment note written by the individual working under the therapist.

Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

PHYSICAL THERAPY PROVIDER REQUIREMENTS

Physical Therapy must be provided by individuals who:

- Are licensed by the Kansas Board of Healing Arts (K.S.A. 65-2901 et seq)
  AND
- Have 40 hours of training in BI or one year of experience working with individuals with BI

Physical Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

ENHANCED CARE SERVICES

Enhanced Care Services (ECS) provides supervision and/or non-nursing physical assistance during a member's normal sleeping hours in his or her place of residence or HCBS setting as approved and authorized on the Integrated Service Plan (ISP). Service providers must remain in the member's home for the duration of this service provision based on the member's normal sleep cycle as documented in the member's ISP. ECS is available to a member who demonstrates an assessed need for a minimum of six hours of sleep support within a 24-hour period and the assessed need cannot be met by the use of PERS, informal support, or other services such as Personal Care Services. The ECS worker must be available to provide immediate supervision or physical assistance with tasks such as, but not limited to, toileting, transferring, mobility, and medication reminders as needed. The ECS provider must be prepared and capable of contacting a doctor, hospital, or medical professional in the event of an emergency.

ENHANCED CARE SERVICES continued

The ECS worker must be able to be awakened and available to provide immediate supervision or physical assistance with tasks such as toileting, transferring, mobility, and medication reminders as needed. Workers must submit a report to the member's MCO care coordinator within the first business day following any emergency response provided.

Health maintenance activities such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, range of motion, and wound care may be provided in accordance with K.S.A. 65-6201. The member's POC must indicate a need for this service that is beyond the need for PERS.

ECS can be provided as a self-directed or agency-directed service.

- Self-directing members or designated representatives are responsible for hiring, supervising, and terminating the employment of PCS workers; understanding the impact of those decisions; and assuming responsibility for the results of those decisions.
- Workers are co-employed by the member and a provider of FMS chosen by the member.
- FMS providers are responsible to provide the member information, assistance, and support with ministerial employer-related functions such as payroll and tax withholding.
- FMS providers provide information related to state and federal rules, employer duties, and HCBS program requirements and responsibilities.
- FMS providers provide assistance with employer-related functions, referrals to community options, and other options available related to member direction.
- Members and agencies employing ECS workers must comply with applicable state and federal employment laws.
- Self-directing members employing ECS workers are subject to the same quality assurance standards as other ECS providers including, but not limited to, completion of the tasks identified on the ISP. (Refer to the *HCBS Financial Management Services Fee-for-Service Provider Manual* for more information.)
- With agency-directed ECS, a qualified agency meeting all the related enrollment requirements manages all aspects of the service.
- Only one unit (a minimum of six hours) is allowed within a 24-hour period. However, ECS workers must be paid in accordance with the member or agency direction as well as state and federal requirements.
- ECS, in combination with other HCBS services, cannot exceed 24 hours within a 24-hour period.
- ECS must not be authorized when a member resides in an assisted living facility (ALF), residential health care facility (RHCF), residential care facility (RCF), home plus, boarding care home, or residential supports for intellectual and development disability that the member has selected as a provider.
- Reimbursement of this service is provided at a flat rate. It is the responsibility of the employer to ensure adherence to all applicable labor regulations.
- Only one ECS worker can be paid for services at any given time of the day. In order to prevent payment for overlapping of services, ECS workers must not be paid for services when another HCBS program service is being provided at the same time on the same day (such as, ECS workers cannot provide services while a member is receiving PCS or therapy). The only

ENHANCED CARE SERVICES continued

exception is when jurisdiction for a two-person lift or transfer is documented on the ISP as necessary to meet the health and welfare needs of the member.

- ECS workers must not provide or be paid for providing ECS, PCS, or other program services for multiple HCBS program members at the same time.
- ECS must not duplicate any personal care services provided through the HCBS program, ***Kansas State Plan for Medicaid***, third-party entity, informal supports, or any other method.
- ECS cannot be provided by a member's legally responsible person (spouse or parent of a minor child) or any individual residing in the home with the member. However, exceptions may be authorized under one or more of the following conditions in accordance with the approved HCBS waivers:
    - The member lives in a rural area, in which access to a provider is beyond a 50-mile radius from the member's residence, and the relative or family member is the only provider available to meet the needs of the member.
    - The member lives alone and has a severe cognitive impairment, physical disability, or intellectual disability.
    - The individual has exhausted other support options by the MCO and without ECS would be at significant risk of institutionalization.

ENHANCED CARE SERVICES EXCEPTION TO LIMITATIONS

Conflict of Interest Policy

- A conflict of interest exists when the person responsible for developing the ISP to address functional needs is also a legal guardian, DPOA, or designated representative and that person is also a paid caregiver for the member. Federal regulations prohibit the individual who directs services from also being a paid caregiver or financially benefitting from the services provided to an individual (42 CFR 441.505, as amended).
- A guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest is mitigated.

Health Maintenance Activities

- In accordance with the Healing Arts Act and the Nurse Practice Act, Health Maintenance Activities can only be performed by a licensed physician or nurse.
    - Nursing assistance can be provided without delegation or supervision if provided for free by friends or members of the member's family (informal supports) as incidental care of the ill member by a domestic servant or in the case of an emergency.
    - Nursing assistance can be provided as part of PCS directed by a member or on behalf of a member in need of in-home care, when the nursing procedure has been delegated through a written physician or RN statement to a member who the physician or nurse knows or has reason to know is competent to perform those activities.
    - If authorized on the member's ISP, a licensed physician or nurse shall provide a written delegation for the following health maintenance activities:
        - Monitoring vital signs
        - Supervision and/or training of nursing procedures
        - Ostomy care
        - Catheter care

ENHANCED CARE SERVICES EXCEPTION TO LIMITATIONS continued

- Enteral nutrition
- Wound care
- Range of motion
- Reporting changes in functions or condition
- Medication administration and assistance

- For agency-directed PCS workers:
  - An attendant who is a certified home health aide or a certified nurse aide shall not perform any health maintenance activities without delegation and supervision by a licensed nurse or physician pursuant to K.S.A. 65-1165.
  - A certified home health aide or certified nurse aide shall not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.
  - An agency shall maintain documentation of delegation by a licensed physician or nurse not employed by the agency. Agencies are responsible for ensuring appropriate supervision of delegated health maintenance activities.
  - Failing to properly supervise, direct, or delegate acts that constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols could result in discipline by the Board of Healing Arts.
- For self-directing members:
  - A member who chooses to self-direct care is not required to have the PCS supervised by a nurse or physician to perform health maintenance activities if both of the following apply:
    - Health maintenance activities can be provided without direct supervision. *". . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the member if the member were physically capable, and the procedure may be safely performed in the home."* K.S.A. 65-6201(d)
    - Health maintenance activities and medication administration and assistance are authorized, in writing, by a physician or licensed professional nurse.
  - The member's failure to properly supervise or direct health maintenance activities delegated to the member by a physician or licensed professional nurse could result in the termination of self-direction for those activities.

Medication Administration and Assistance

- Provided in a licensed facility
  - Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.
  - Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.

ENHANCED CARE SERVICES EXCEPTION TO LIMITATIONS continued

- If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.

- Provided in a private residence
  - A KDHE-licensed or Medicare-certified Home Health Agency can provide nursing delegation to aides with sufficient training. The nurse delegation and training shall be specific to the particular member and his or her health needs. The qualified nurse retains overall responsibility.
  - Medicare-certified Home Health Agencies and state-licensed Home Health Agencies may perform medication administration and assistance in accordance with their licenses.
  - Self-directing members employing PCS workers who have a written physician's or registered nurse's statement to delegate health maintenance activities, including medication administration and assistance, are responsible to supervise PCS workers and train them to administer medication according to the physician's orders.

ENHANCED CARE SERVICES DOCUMENTATION

- ECS paid by the HCBS program is limited to the number of hours/units authorized on the ISP and in the AuthentiCare Kansas system.
- ECS workers for both agency-directed and self-directed employers are required to use AuthentiCare Kansas. This is necessary to comply with federal requirements to ensure the health safety of members and to prevent fraud, waste, and abuse.
- Documentation must be generated at the time of the visit. Generating documentation after the time of the visit is not acceptable.
- Documentation must be clear and self-explanatory, or reimbursement may be subject to recoupment.
- Documentation must be uploaded to AuthentiCare Kansas by the FMS provider and in the member's file as documented in the member's ISP as appropriate.

The provision of self-directed ECS must be documented by using AuthentiCare Kansas and its IVR system. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided
- Identification of the member receiving the service (first and last name)
- Identification of the worker providing the tasks
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

For agency-directed ECS and those limited instances where the self-directing member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided

ENHANCED CARE SERVICES DOCUMENTATION continued

- Member's printed name (first and last) and signature on each page of documentation (see Signature Limitations)
- Worker's printed name and signature on each page of documentation
- Date of service (month/day/year)
- Start time for each visit, using AM/PM or 2400 clock hours
- Stop time for each visit, using AM/PM or 2400 clock hours
- Identification of activities performed during each visit

Documentation must be generated at the time of the visit. Generating documentation after-the-fact is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.

ENHANCED CARE SERVICES REIMBURSEMENT

A Medicaid member is eligible only for the number of ECS units per week as specified in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved ECS units for a member cannot exceed the number of weekly ECS units approved on the monthly POC.

ENHANCED CARE SERVICES PROVIDER REQUIREMENTS

ECS must be provided by individuals who:

- Are at least 18 years of age or have a high school diploma or equivalent
- Are able to contact the appropriate person(s) in case of an emergency and provide the intermittent care the individual may need
- Have had a background check with no prohibited offenses prior to providing support services in accordance with the KDADS background check policy
- Meet the provider qualifications for providing ECS as defined in the HCBS program waiver

An adult member's spouse or a minor member's parents must not be paid to provide this service unless granted an exception by the BI program manager as outlined in K.A.R. 30-5-307.

Agencies providing ECS must enroll with the State's fiscal agent. Individual, non-enrolled providers must enter into an agreement with an enrolled provider of FMS.

SPEECH/LANGUAGE THERAPY

Speech/Language Therapy is the treatment of speech and/or language disorders, such as problems with the actual production of sounds and difficulty understanding or putting words together to communicate ideas. Assessment and treatment of persons with BI may include the areas of language (listening, talking, reading, writing), cognition (attention, memory, sequencing, planning, time management, problem solving), motor speech skills and articulation, and conversational skills. Speech/Language Therapy can also address issues related to swallowing and respiration. Goals for the person with BI will depend on the individual's level of functioning, with the overriding focus being to regain lost skills and/or learn ways to compensate for abilities that have permanently changed to help the individual achieve the greatest level of independence possible.

SPEECH/LANGUAGE THERAPY continued

Speech/Language Therapy waiver services are provided when the limits of the approved Speech/ Language Therapy State Plan service (for example, up to six months postinjury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the ***Kansas State Plan for Medicaid*** are provided according to the member's needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, which is that the member continues to make progress in his or her rehabilitation.

SPEECH/LANGUAGE THERAPY LIMITATIONS

There is a limitation of 3120 units (one unit equals 15 minutes) per member, per calendar year, for any combination of the following HCBS BI therapies: behavior, cognitive, occupational, physical, and speech/language.

SPEECH/LANGUAGE THERAPY DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet the objectives of being restorative and rehabilitative. Members' files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing evaluations of the effectiveness of therapy, and any observations that have been made. Documentation must be legible, accurate, and timely. Members' files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

Each visit must be documented. Documentation must include:

- Service being provided
- Member's first and last name
- Date of service (month/day/year)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Narrative log that describes the treatment provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials

Supervision of an individual working under the enrolled speech/language therapist must be clearly documented. This may include, but is not limited to, the therapist initializing each treatment note written by the individual working under the therapist.

Time should be totaled by actual minutes/hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

SPEECH/LANGUAGE THERAPY PROVIDER REQUIREMENTS

Speech/Language Therapy must be provided by individuals who:

- Are licensed by the Kansas Department of Health and Environment
  AND
- Have 40 hours of training in BI or one year of experience working with individuals with BI

Speech/Language Therapy can be provided by an individual under the supervision of the enrolled, qualified provider.

TRANSITIONAL LIVING SKILLS

Transitional Living Skills (TLS) involves the assessment and provision of community and in-home training and personal care services designed to prevent and/or minimize chronic disabilities while restoring the member to an optimal level of physical, cognitive, and behavioral functioning within the context of the person, family, and community. The primary purpose of TLS services is to provide opportunities for members to develop and/or relearn skills necessary to optimize independence and enhance the individual's quality of life.

TLS are comprehensive in nature and, therefore, address multiple aspects of an individual's needs and goals to achieve as much independence as possible. Training follows a model in which individuals with BI practice skills in real-life situations in their homes and communities where the skills would naturally be utilized. TLS services are designed to teach individuals how to become more self-sufficient through the application of these skills, which include but are not limited to, the following skill areas: household management, disability and social adjustment, problem solving, functional communication, transportation and mobility, resource acquisition, self-management, and community living. TLS services are expected to decrease as the individual's skills increase.

TRANSITIONAL LIVING SKILLS LIMITATIONS

- The provision of TLS is to be based on a POC and should be provided in the member's residence or in a setting where the skills would naturally occur.
- Training may be provided up to 7 days per week, with a maximum of 4 hours (16 15-minute units) daily and 3120 15-minute units per year.
- Family members cannot be reimbursed for providing this service. Family members include but are not limited to parents, spouses, aunts, uncles, brothers, sisters, first cousins, and any step-family relationships.
- TLS services are to be provided on a one-on-one basis. They cannot be provided in a group setting in which multiple members are given instruction simultaneously.
- The TLS assessment phase can be no more than 30 days.

TRANSITIONAL LIVING SKILLS DOCUMENTATION

Documentation is the responsibility of the provider of the service. Documentation must be clear, concise, and factual. Documented activities should be goal-directed to meet related training objectives. The member's files must include updated goals and objectives that include target dates, summaries of relevant activities, a chronological history, ongoing assessments of the effectiveness of training, and any observations that have been made. Documentation must be legible, accurate, and timely. The member's files may be used for supervisory reviews, HCBS Special Services Team (HSST) reviews, quality assurance reviews, and issues related to client obligations.

TRANSITIONAL LIVING SKILLS DOCUMENTATION continued

Each visit must be documented. Documentation must include:

- Service being provided
- Member's first and last name
- Date of service (month/day/year)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Narrative log that describes the training provided and identifies the corresponding goals and objectives
- Service provider's printed name and signature with credentials (TLS)

Time must be totaled by actual minutes and hours worked. Billing staff may round the total to the quarter hour at the end of the billing cycle. Providers are responsible to ensure the service was provided prior to submitting claims.

Documentation must be completed at the time of the visit. Generating documentation after this time is not acceptable. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

TRANSITIONAL LIVING SKILLS PROVIDER REQUIREMENTS

TLS must be provided by a center for independent living (as defined in K.A.R. 30-5-300 (a)(21) or a licensed home health agency (as defined in K.S.A. 65-5001 et seq) enrolled to provide this service.

Individuals who provide TLS services are required to be trained by the HCBS BI waiver provider for whom they are employed by using the *Transitional Living Skills Training Manual* on the KDADS website.

The TLS specialist candidate must complete the test that accompanies each module of the manual at a comprehensive level of 80% or better. (The TLS test can be accessed at https://www.train.org/ks/) The HCBS BI waiver provider who employs the TLS specialist is responsible for ensuring that the TLS specialist has successfully completed the training and passed the test.

Individual TLS specialists must receive 28 hours of training in BI. This mandatory curriculum is a basis for the required 28 hours of training.

BRAIN INJURY WAIVER
DETERMINATION OF PROGRESS AND CASE REVIEW

Updated 08/20

The Kansas BI Waiver is a transitional waiver designed to provide relatively short-term services to assist people with achieving greater levels of independence. The waiver is not intended to provide permanent, long-term care services. Eligibility for the BI waiver includes the following criterion: The individual must show the capacity to make progress in his or her rehabilitation and independent living skills.

To determine whether a recipient of BI waiver services is making progress, it is essential that the individual receive one or more waiver services from which measurable progress can be evaluated (i.e., TLS, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Cognitive Rehabilitation, Behavior Therapy). Without this information, a consumer will be considered ineligible for waiver services. For this reason, if any 60-day period lapses when none of these services can be provided after the initial POC has been approved, either due to lack of availability or nonparticipation on the part of the consumer, the consumer's case must be transferred to an agency that can provide the service, the individual should be referred to another waiver (if appropriate), or the consumer's case should be closed.

The rehabilitative progress of people receiving BI waiver services should be reviewed on an ongoing basis by the MCO care coordinator, along with the TLS specialist and therapists, if applicable. If a consumer is approaching four years of receiving waiver services and wishes to continue receiving services beyond four years, and the consumer and BI TCM believe that the individual continues to meet the waiver eligibility criterion of making progress in rehabilitation and independent living skills, then a completed Progress Review form and other supporting documentation must be submitted to the BI program manager, who will conduct a formal review. The review process will take into consideration the following information:

"Progress" means one or more of the following:

- Improvement with daily living skills (i.e., ADL, IADL)
- Improvement with physical functioning
- Improvement in speech/communication
- Improvement in cognitive abilities
- Improvement in behavioral functioning

Evidence that a person is making progress includes:

- Sustained decrease in the degree of difficulty the person has with daily living skills
- Sustained decrease in the frequency of behavior issues
- Sustained decrease in the degree of difficulty with cognitive issues
- Sustained decrease in the need for services
- Sustained, observable/measurable improvement with therapy
- Sustained decrease in the LTC Threshold score

BRAIN INJURY WAIVER
DETERMINATION OF PROGRESS AND CASE REVIEW

Updated 08/20

Evidence of progress is provided using:

- BI Uniform Assessment Instrument scores
- BI Addendum scores
- POCs
- Goal Plan for independent living
- Therapy progress reports

After the BI program manager has completed the review, the BI TCM will be notified of the determination. If the BI program manager confirms that the consumer continues to meet the criterion of making progress, the consumer may continue to receive waiver services, although the individual's case will be reviewed on no more than an annual basis. If, however, it is determined that the consumer is no longer making progress, a target date for transition to another waiver or closure of the case will be given.

If the TCM and the consumer disagree with the determination, a letter explaining why the consumer should continue to receive services accompanied by a completed Transition Plan document may be submitted for further consideration.

The person receiving services has the right to file a timely appeal with the Office of Administrative Hearings regarding termination of services, as explained in the Consumer Rights and Responsibilities document.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS BI SERVICES

Updated 08/24

1. Services are provided according to the POC, in a quality manner, and as authorized on the NOA.
2. Provision of services is coordinated in a cost-effective and quality manner.
3. Member's independence and health are maintained, where possible, in a safe and dignified manner.
4. Member's concerns and needs, such as changes in health status, are communicated to the MCO care coordinator within 48 hours, including any ongoing reporting as required by the Medicaid program.
5. Any failure or inability to provide services as scheduled in accordance with the POC must be reported immediately, but at least within 48 hours, to the MCO care coordinator.

KDADS has established an adverse incident reporting and management system in accordance with the statutory requirements under 1915 (c) of the Social Security Act and the health and welfare waiver assurance and associated sub-assurances.

Adverse Incident Reporting & Management
The Adverse Incident Reporting (AIR) system is designed for KDADS service providers and contractors to report all adverse incidents and serious occurrences involving individuals receiving services from KDADS. Providers can access the AIR system from the KDADS Home page under the **Quick Links** heading.

I. General Requirements
   A. All HCBS providers shall make adverse incident reports in accordance with this policy as set forth herein.
   B. All adverse incidents including those required to be reported to the Department of Children and Families (DCF), shall be reported to KDADS by direct entry into the KDADS web-based AIR system no later than 24 hours after becoming aware of the adverse incident.
   C. Incidents shall be classified as adverse incidents when the event brings harm or creates the potential for imminent serious harm to any individual eligible to receive HCBS waiver services at the time of the occurrence.
   D. A report shall be made into the AIR system for any adverse incident regardless of the location where it occurred. Location includes, but is not limited to, any premises owned or operated by a provider or facility licensed by KDADS; operating under the Older Americans Act or the Senior Care Act; or operating under the Money Follows the Person program or the Behavioral Health Services programs.
   E. KDADS Program Integrity and Compliance (PIC) shall offer AIR system training to MCO staff, and all interested and involved parties. Training materials shall be provided on site and on the KDADS website.

Updated 02/25

II. Adverse Incident Definitions

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

B. **Chemical Restraint**: Any medication used to control behavior or to restrict the member's freedom of movement and is not a standard treatment for the member's medical or psychiatric condition.

C. **Death:** Cessation of a member's life.

D. **Elopement:** The unplanned departure from a unit or facility where the member leaves without prior notification or permission if there is a documented concern for safety in the community.

E. **Emergency Medical Care:** Inpatient or outpatient emergency medical services that are necessary to ensure the health and welfare of the member which require use of the most accessible medical facility.

F. **Exploitation:** Misappropriation of the member's property or intentionally taking unfair advantage of a member's physical or financial resources for another individual's personal or financial gain by the use of undue influence, coercion, harassment, duress, deception, false representation, or pretense by a caretaker or another person.

G. **Fiduciary Abuse:** A situation in which any person who is the caretaker of, or who stands in a position of trust to, a member, takes, secretes, or appropriates their money or property to any use or purpose not in the due and lawful execution of such person's trust or benefit.

H. **Law Enforcement Involvement:** Any communication or contact with a public office that is vested by law with the duty to maintain public order, make arrests for crimes, and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.

I. **Misuse of Medications:** The incorrect administration or mismanagement of medication by someone providing HCBS which results in or could result in serious injury or illness to a member.

Updated 08/24

I. Adverse Incident Definitions continued

A. **Natural Disaster:** A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life. Approved emergency management protocols are to be followed, documented, and reported as required by the policy in the AIR system. A separate AIR report shall be made for all HCBS members in the area who are impacted by the natural disaster.

B. **Neglect:** The failure or omission by a caretaker, or another person with a duty to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

C. **Physical Restraint**: Any manual method of physical object or device attached or adjacent to a member's body that restricts the member's freedom of movement.

D. **Seclusion:** The involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving.

E. **Self-Neglect:** The failure or omission by oneself to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

F. **Serious Injury:** An unexpected occurrence involving the significant impairment of the physical condition of a member. Serious injury specifically includes loss of limb or function.

G. **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

H. **Suicide Attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

II. Adverse Incident Reporting Requirements

A. Reporting Abuse, Neglect, Exploitation (ANE), and Fiduciary Abuse:

1. ANE and Fiduciary Abuse shall be reported to DCF as required by K.S.A. 39-1431, K.S.A. 38-2223.
2. ANE and Fiduciary Abuse reported to DCF shall also be reported to KDADS. When ANE and Fiduciary Abuse is reported to KDADS, the report shall identify the date of report to DCF and the intake number.
3. ANE and Fiduciary Abuse reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
4. ANE and Fiduciary Abuse reports require KDADS confirmation before final resolution. KDADS shall verify the following:
    a) A preventable cause was accurately identified; and
    b) The MCO observed appropriate follow-up measures.
5. The MCO investigation shall verify the following:
    a) That appropriate follow-up actions are taken against the alleged perpetrator to minimize the risk of reoccurrence; and
    b) That appropriate supports are in place to assist the alleged victim to address any concerns they may have as a result of the occurrence.

Updated 08/24

A. Reporting Seclusion, Physical Restraint and Chemical Restraint

1. Seclusion, Physical Restraint, and Chemical Restraint reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
2. Seclusion, Physical Restraint, and Chemical Restraint reports shall require KDADS confirmation before final resolution. KDADS confirmation process shall examine if:
    a) The intervention was authorized or unauthorized; and
    b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.
3. The MCO investigation shall verify that:
    a) The application of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, complied with the procedures specified in the approved waiver; and
    b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.
4. Chemical Restraint Reporting: The requirement for reporting chemical restraints is to provide tracking and trending data to ensure the health and welfare of the member. Follow-up measures shall verify that the necessary supports are in place for the member.
    a) Authorized Use of Chemical Restraint: Authorized use of chemical restraint is defined as the administration of any medication which follows the member's current Person-Centered Service Plan (PCSP).
        i. The medication must be prescribed and approved by a licensed healthcare provider.
        ii. The approved use must comply with the policy established per the setting.
        iii. Medication administration must follow the member's PCSP.
        iv. Any prescribed medication with the intended purpose of altering a member's behavior as warranted by the current situation. A report is required when a prescribed medication is administered on an interval beyond or at a dosage above the routinely scheduled regimen as documented in the member's PCSP.
    b) Unauthorized Use of Chemical Restraint: Unauthorized use of chemical restraint is defined as the administration of any medication that is not authorized for use in the member's current PCSP.
        i. A report must be filed whenever medication is administered as a chemical restraint, as defined above, regardless of whether it is prescribed or over the counter. No reporting is necessary if the medication is administered within the confines of its prescription and is not used as a chemical restraint.

Updated 08/24

B. Reporting Death
    1. Death reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
    2. Death reports require KDADS confirmation before final resolution. KDADS shall verify the following:
        a) The deceased's expectancy of death was accurately reported.
        b) The deceased's hospice status was accurately reported.
        c) Any preventable cause was accurately identified; and
        d) The MCO observed appropriate follow-up measures.
    3. The MCO investigation shall verify:
        a) If the death was expected or unexpected.
        b) If there was a preventable cause of death; and
        c) If the deceased was a recipient of hospice, then the MCO shall verify supporting documents in the form of a physician's order or hospice admission documentation.

C. Reporting of All Other Adverse Incidents.
    1. The reporting of all other adverse incidents, as defined in this policy, not required via K.S.A. 39-1433, K.S.A.38-2223, shall be made through the AIR system.

Military Inclusion
Active duty or honorably discharged military personnel and/or immediate family members are permitted to bypass the waitlist for HCBS programs in acknowledgment of their dedication and service to the United States of America.

I. Policy

A. KDADS determines HCBS waiver program eligibility for all HCBS waivers in the State of Kansas.
    1. Each current and approved HCBS waiver program has reserved capacity for active or honorably discharged military personnel and/or immediate family members.

B. Active or honorably discharged eligible military personnel and/or immediate family members (eligible dependents) may bypass the HCBS program waitlists, and access services, if the following criteria are met:
    1. The military personnel must show proof of active-duty service or an honorable discharge.
        a) Proof of active service or honorable discharge shall be any of the following:
            i. Most recent copy of Leave and Earning Statement (LES)
            ii. Valid Military Identification Card
            iii. Certificate of Release or Discharge from Active Duty (Form DD-214)
    2. The military personnel, or eligible dependent, must present documentation showing proof of:
        a) Coverage under Tricare Extended Care Health Option (ECHO) during the time of military service; or
        b) Coverage under Tricare ECHO at the time of separation from active military service.

3. Be a Kansas resident, by maintaining or demonstrating the intent to make Kansas the principal place of residency, consistent with K.S.A.79-39,109 and K.A.R. 95-12-4a.
    a) Evidence supporting residency or demonstrating the intent to establish residency, may include, but is not limited to, the following:
        i. Proof eligible military personnel is registered to vote in Kansas
        ii. Proof eligible military personnel has filed a Kansas resident income tax return for the most recent taxable year
        iii. Proof eligible military personnel have current motor vehicle registration in Kansas
        iv. Proof eligible military personnel hold a current valid Kansas driver's license or non-driver identification card
4. A dependent of military personnel residing in the state of Kansas may qualify for military inclusion exception.
    a) A qualifying dependent must meet the criteria for dependency as defined by the Internal Revenue Service (IRS).
    b) Evidence supporting dependency may include, but is not limited to, the following:
        i. Recent tax return
        ii. Marriage license
        iii. Birth certificate
        iv. Court order
        v. Adoption documentation
5. The eligible military personnel or their eligible dependent must meet the functional eligibility, program eligibility, and financial eligibility requirements for the HCBS waiver program that they have requested.
    a) Financial eligibility for all HCBS waiver programs is determined by the KDHE.

II. Procedures

A. Functional Eligibility Determination
1. If an active or honorably discharged military personnel and/or their dependent is referred to an assessing entity for functional assessment, and if the individual requests an exception based on military inclusion, the assessor shall collect the proof of the following:
    a) Kansas residency
    b) Military member's or dependent's Tricare Echo Verification Documentation, and
    c) Proof of active-duty service through documentation (such as Form DD-214)
    d) Proof of dependency on qualified military personnel (when applicable)

B. Applicant shall provide required supporting proof of military service to the assessing entity at the time of functional assessment:
1. If such documentation is not available at the time of functional assessment, the assessor shall proceed with completing a functional assessment based upon applicable current/approved waiver program requirements, policy, and procedures.

a) Supporting proof of military service must be provided to the state's designated system of record no later than five days after the functional assessment to be considered for inclusion exception during program eligibility determination.
b) The assessor must notify the appropriate HCBS Program Manager, or designated state agency, of receipt and validation of the appropriate documentation showing qualification for military inclusion exception.

C. For individuals separating from active-duty military service:
1. A functional assessment must be completed within 30 days of termination of active duty or separation from military service to be considered for the military inclusion exception.
2. If an individual meets the functional eligibility but fails to meet the requirements for a military inclusion exception, then the individual may:
a) Access an HCBS program in the same manner as any other applicant found functionally eligible; or
b) Be placed on the appropriate waitlist as of the date of functional eligibility if the qualifying HCBS program has a waitlist.

D. After validating the proof of military service and determining that an eligible military personnel or eligible dependent meets the requested HCBS waiver functional eligibility criteria:
1. The assessor shall follow functional assessment and waiver eligibility procedures of the relevant HCBS waiver program.
a) The assessor shall notify, using the state-designated communication method, the appropriate HCBS Program Manager, or designated state agency, of receipt and validation of the appropriate documentation showing qualification for military inclusion exception listed in the Section I of this policy.
2. KDADS may request the supporting documentation proving eligibility for military inclusion exception from the assessor, or directly from the individual deemed eligible for military inclusion exception to support a program eligibility determination.

E. If the assessor determines the individual seeking military inclusion exception for themselves or their dependent is not functionally eligible for the HCBS waiver program:
1. The assessor shall follow waiver policies and procedures applicable to the waiver program that the applicant has applied.
2. The assessor shall counsel the applicant on alternative community options and services, including services available through the Veterans Affairs (VA) Administration.

III. Documentation

A. KDADS HCBS Program Manager shall follow established current/approved HCBS waivers, policy, and procedures in requesting and responding to requests for waiver program eligibility.

Updated 11/21

IV. Definitions

A. **Dependent/Immediate Family Members** – As defined by the Internal Revenue Service (IRS), a spouse, child, parent, brother, sister, grandparent, grandchild, step-parent, step-child, step-brother, or step-sister of the individual in the military (IRM 1.25.1.2.2) who is claimed on the military personnel's federal income tax return as a dependent qualifying widower and dependent child, qualifying child or qualifying relative as established in the IRS Publication 501.

B. **Financial Eligibility** – The process whereby a member is determined to be eligible for health care coverage for reimbursement through Medicaid as determined by an authorized agent or personnel designated by the State. In this case, the Single State Medicaid Agency is the KDHE.

C. **Functional Assessment** – The current KDADS approved tool used by a state-contracted assessor to assess a person's functional eligibility.

D. **Functional Eligibility -** The process whereby a member is determined to meet the level of care need for an institutional setting to access a Medicaid-funded HCBS waiver program as determined by a state-contracted assessor.

E. **Military Personnel** – Active or reserve duty members of the armed forces including the United States Army, Navy, Marines, Air Force and Coast Guard, as well as, the activated Kansas National Guard.

F. **Program Eligibility** – The process whereby a member is determined to be eligible for a Medicaid-funded KDADS HCBS waiver program as determined by KDADS or its designated State agency.

G. **Resident** – A citizen of the United States who has a fixed home in Kansas, does not intend to leave Kansas and whenever absent, if for temporary purposes, intends to return to Kansas as evidenced by several factors found in K.A.R. 92-12-4a, including, but not limited to, spending more than six months of the taxable year in Kansas, voting or being registered to vote in Kansas, obtaining or maintaining a current valid driver's license or non-driver identification card, and paying Kansas income and property taxes and that person's domicile is within Kansas.

H. **State-contracted Assessor** – Authorized agent or personnel, approved by the State, responsible for completing the functional eligibility assessments for individuals applying for KDADS HCBS waiver programs.