Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS Intellectual/ Developmentally Disabled

Updated 06.2026

PART II
HCBS INTELLECTUAL/DEVELOPMENTALLY DISABLED
FEE-FOR-SERVICE PROVIDER MANUAL

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FORMS All forms pertaining to this provider manual can be found on the Kansas Medical Assistance Program (KMAP) public and secure portals Publications and Form.

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 (MCOs), reference the KanCare website. Contact the specific health plan for managed care assistance.

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INTRODUCTION TO THE HCBS I/DD PROGRAM

Updated 10/24

The Home and Community Based Services (HCBS) Intellectual/Developmentally Disabled (I/DD) program is designed to meet the needs of members who would be institutionalized without these services. The variety of services described 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 the HCBS program.

- Assistive Services
- Children's Integrated Community Supports (CHICS)
- Day Supports
- Enhanced Care Services
- Financial Management Services (FMS)*
- Medical Alert-rental
- Overnight Respite
- Personal Care Services
- Residential Supports
- Specialized Medical Care
- Supportive Home Care
- Wellness Monitoring

*Refer to the *HCBS Financial Management Services (FMS) Fee-for-Service Provider Manual* for criteria and information.

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

Hcbs I/DD Enrollment

HCBS I/DD providers must enroll and receive a provider number for HCBS I/DD program services. Access provider enrollment information on the Provider page of the KMAP portal.

General

- Prior to completion of a functional assessment by a community developmental disability organization (CDDO), the individual must be determined to have a qualifying intellectual/ developmental disability as defined in the Developmental Disabilities Reform Act.
- All functional assessments shall be performed by CDDO staff or by an entity that has entered into an agreement with the CDDO to perform functional eligibility assessments.
  Note: Contracted entities shall not provide any direct services to any individual being assessed.
- The basic assessment and services information system (BASIS) is the current functional assessment information system used to maintain functional eligibility assessments for the HCBS I/DD waiver program.
- All functional assessments must be conducted in-person at a location of the individual's choosing, or, if available, through the use of real-time interactive telecommunications equipment that includes, at a minimum, audio and video equipment. Those responsible for conducting the assessment will be flexible in accommodating the individual's preference for the meeting location and time of assessment.
- For all individuals offered services, the MCO will authorize services as specified in the POC within 14 business days after it receives an 834 file reflecting the individual's eligibility for those services.
- Upon an initial assessment and annually thereafter, for those receiving HCBS I/DD services, the CDDO shall collect a signed statement providing evidence the person has been provided comprehensive options counseling by the CDDO. A copy of the signed statement will be provided to the member's MCO.

General continued

- The statement shall provide the following information:
  - The date the options counseling was provided.
  - The names of the individual, the individual's family members, the individual's legal guardian, if one has been named, and/or significant other who participated in the meeting with the Community Options Specialist.
  - A listing of options discussed with the individual.
- The statement shall be used by the CDDO to provide individuals with information on available service providers, provider contact information, and to assist in seeking answers to questions the individual may have regarding providers and services.
- The signed statement shall be uploaded as an attachment to the initial and annual assessment. In cases where options counseling is performed outside the assessment, the signed statement shall be uploaded via the Kansas Department of Aging and Disability Services' (KDADS') "I/DD Utility Upload" tool.

Functional Assessments

Functional Eligibility Determination

- An initial assessment must be completed upon I/DD eligibility determination and/or upon the individual attaining the age of five years and acknowledging a willingness to accept services upon receiving an offer of services.
  Note: Functional assessments are not required for immigrants who do not meet the definition of a "qualified noncitizen" because they are ineligible to receive Medicaid benefits.
- A person must achieve a minimum converted score of 35 or more to meet the HCBS I/DD waiver program threshold.
- Children who are 5 to 11 years of age must score at least a 21 on the children's assessment and achieve a minimum converted score of 35 or more.
- The assessment shall be initiated within 5 business days and completed within 20 business days from the date of I/DD eligibility determination.
- The CDDO shall enter the data from the assessment and reassessment into the KDADS' system of record (currently KAMIS) and utilize the information system for collecting and updating data.
- The CDDO has 7 business days from the date of completing the assessment to enter the assessment into the KDADS' system of record (currently KAMIS). Completion of assessment shall be defined as provision of all supporting documentation and provision of the in-person assessment.
  Note: An exception to this requirement may be applied in varied and unique circumstances with approval from the I/DD program manager. The member's MCO will receive notification of the exception from the program manager.

Reassessments

- Persons with reasonable indicators of meeting level of care eligibility are evaluated upon initial application for services and then reevaluated annually, within 365 days of the last assessment. Reassessments shall include individuals not on the waiting list who are state-funded and/or received a previous assessment of Tier 0.

Reassessments continued

- If a reassessment is desired outside of the annual assessment as prescribed above or the annual assessment is not required, the request for such special reassessment shall be provided to and reviewed by the HCBS I/DD program manager prior to completion of the reassessment. The HCBS I/DD program manager shall respond to each request within 10 business days from the date the request was received.
- An annual reassessment is not required for individuals placed on the waiting list.
- Individuals on the waiting list seeking a crisis or exception request, and having a BASIS assessment older than 365 days, are preauthorized to receive a BASIS assessment prior to submission of a crisis or exception request. The CDDO will notify the member's MCO of the request.
- Any tier change resulting from a reassessment shall become effective the first day of the month following the completion of the reassessment.

Assessor Qualifications

Assessors must meet the following provider qualifications prior to administering a functional assessment:

- Must have a minimum of six months experience in the field of developmental disabilities
  Note: An exception may be granted by KDADS on an individualized basis. In such cases, the exempted person must work under the direct supervision of a qualified person.
- Must possess a bachelor's degree or additional experience in the field of intellectual/ developmental disabilities. Experience may substitute for the required education at the rate of six months of experience for each semester.
- Must complete required assessment training within 30 days from employment and at least annually thereafter.

Assessment Disputes and Notice of Action

- Upon completion of the functional eligibility assessment, KDADS shall issue the Notice of Action (NOA).
- If a functional assessment determines an individual is ineligible for services, the individual shall have the right to appeal.
- The NOA issued shall provide the following information for those seeking to appeal the functional assessment determination:
  - A request for a state fair hearing must be in writing and signed.
  - State fair hearing requests must be sent within 30 days of this NOA. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice is mailed. The request must be sent to:
    The Kansas Department of Administration
    Office of Administrative Hearings
    1020 S. Kansas Ave.
    Topeka, KS 66612
  - In the event your request for a state fair hearing is granted, you may represent yourself or be represented by legal counsel, a relative, a friend, or a spokesperson.
- If during the annual functional reassessment, a change in the individual's tier score occurs, but the individual remains eligible for HCBS I/DD services, the individual shall not have the right to appeal.

Recoupment

- If during a quality review or other instance it is determined the functional assessment was not applied accurately, KDADS may recoup the previous payment for the inaccurate functional assessment.
- If during a quality review or other instance it is determined a functional assessment was not completed within the required time frames as documented in waiver performance measures, KDADS shall recoup any previous payments for such assessments.

HCBS I/DD Waiting List

- KDADS shall maintain a single statewide HCBS I/DD waiting list for individuals waiting to receive services from the HCBS I/DD program.
- KDADS shall provide CDDOs access to the waiting list at least on a semi-annual basis. The list shall include the following:
    - Individual's name
    - Individual's Social Security number (SSN)
    - Date added to the waiting list
      Note: The date the individual is added to the waiting list will be equivalent to the most recent functional assessment verifying HCBS I/DD waiver eligibility (such as Tier 1, Tier 2).
- If an individual moves from one CDDO area to another, they shall retain their place on the waiting list.
- Prior to placement on the I/DD waiver waiting list, the individual must:
    - Be determined eligible for the I/DD program.
      Note: All non-U.S. citizens must meet the requirements of a "qualified non-citizen", as defined by federal Medicaid law, before being placed on the I/DD waiver waiting list.
    - Be determined functionally eligible for I/DD waiver services using the approved functional assessment tool.
      Note: The date of a completed functional assessment, which determines functional eligibility, shall be the date an individual is added to the waiting list.
    - Be a legal resident of Kansas, as defined in K.A.R. 92-12-4a.
    - Not be a recipient of other HCBS waiver services, with the exception of individuals currently receiving services through the Serious Emotional Disturbance (SED) waiver.
    - Be willing to accept services upon offer of service.
- Individuals who refuse I/DD waiver services when an offer of service is made shall be removed from the waiting list.

Updated 12/25

Procedures

Functional Assessment

- The individual, their legal representative, or their family member contacts the CDDO concerning I/DD services. Initial referrals may come from KDADS/KDHE or the individual's MCO.
- The CDDO completes the intake process and determines I/DD eligibility.
- Initial assessment and reassessments as identified in Policy Section II – Functional Assessments shall be completed by the CDDO and loaded into KAMIS.
- Following the functional assessment, if the individual assessed agrees to accept services if/when offered, "waiting for service" shall be marked "yes".

Quality Assurance and Reporting Requirements

Quality Assurance

KDADS shall review a sample of completed functional assessments for completeness and accuracy. Quality assurance reviews will be conducted on the initial assessment and annual reassessments to ensure:

- The assessment tool was applied accurately.
- The initial assessment and annual reassessments were conducted within the specified timeline.
- The initial assessment and annual reassessments were conducted by a qualified assessor.
- The assessments submitted were completed correctly and addressed all required elements including, but not limited to, documentation supporting the recorded information on the assessment (such as behavior support plans and frequency of behaviors).

Updated 01/22

Reporting Requirements

- The CDDO shall submit an annual (calendar year) report to KDADS, in the prescribed format and naming conventions, by the 20th day following the end of each calendar year. This report will be sent to the KDADS.HCBS-KS@ks.gov email address.
- This report shall include the following information:
    - The number of people requesting functional assessments, including initial assessments and reassessments.
    - The number of initial assessments completed.
    - The number of people initially assessed who did not meet functional eligibility requirements.
    - The number of people referred but assessment was not completed due to one of the following:
        - Move
        - Institutionalization (state hospital – OSH, LSH, Parsons, KNI; Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID); and nursing facility)
        - Death
        - Other
    - The number of reassessments completed.
    - The number of reassessments not completed due to the following:
        - Move
        - Death
        - Transition off waiver
        - Other
    - A list of current BASIS assessors. The list shall include the following information:
        - Date of employment
        - Date BASIS web-based training certificate acquired
        - Evidence supporting status of college degree
        - Number of years of experience in the I/DD field
        - Date of termination (if applicable)

Updated 12/25

HCBS I/DD Waiting List Management

- KDADS shall provide written notification to the individual, CDDO, and MCO when an individual is offered services from the waiting list.
- The CDDO and MCO shall make every reasonable attempt to make immediate contact with all individuals offered HCBS I/DD waiver services.
- KDADS shall issue a notice identifying a date of removal from the waiting list should the individual fail to respond within 15 days and accept the services offered.
- If an individual on the waitlist declines services but wishes to remain on the waitlist for future consideration, the Participant will be reassessed by the CDDO
- If no response is received from the initial notice, KDADS shall issue a NOA to the member or legal guardian of the action that will be taken. The NOA provides information regarding filing an appeal with the Office of Administrative Hearings. The CDDO and MCO shall receive a copy of the NOA issued to the member or legal guardian.
- After 30 calendar days from the date of the NOA, individuals who have failed to respond will be removed from the waiting list.
- CDDOs shall submit the I/DD Notification Form via the IDD Utility Upload to request a person be removed from the waiting list. The MCO shall submit Form 3161 to the I/DD program manager via email to request a person be removed from the waiting list following no response from the individual.
- To be reinstated on the I/DD waiver waiting list, individuals who either voluntarily or involuntarily were removed from the waiting list shall be required to meet all eligibility criteria documented in this policy. Individuals who have not completed the functional eligibility assessment within 365 days from the date of the requested reinstatement shall be required to be reassessed.

Criteria for the Crisis and Exception Process

General

- All persons requesting access to HCBS I/DD waiver program services must meet I/DD eligibility determination standards and functional eligibility requirements.
- All requests for crisis or exceptions to the HCBS I/DD waiting list will be made through the CDDO in the area which they reside.
- All crisis and exception requests will be uploaded into the KDADS IDD Utility Upload tool.
- Prior to submission of a crisis or exception request, the person must have a current functional eligibility assessment performed within the past 365 days. If the person requesting crisis has a functional eligibility assessment greater than 365 days, a functional eligibility assessment shall be performed prior to the crisis or exception request submission.

Updated 03/17

Criteria for the Crisis and Exception Process continued

Crisis Requests and Required Documentation

- The person requesting access to HCBS I/DD waiver programs services, who is in crisis or imminent risk of crisis, may submit a crisis request for review based on the process as provided in KDADS policy.
- Persons shall be determined to be in crisis under the following conditions:
  - Documentation from law enforcement or the Kansas Department for Children and Families (DCF) supporting the need for the person's protection from confirmed abuse, neglect, or exploitation (ANE)
  - Documentation substantiating the person is at significant, imminent risk, and is capable of performing serious harm to self or others
- CDDOS are responsible for providing all supporting documentation necessary to render a determination for a crisis request. This documentation includes but is not limited to the following:
  - CDDO Notification form
  - Person-centered support plan (PCSP) which demonstrates need

  Note: If the person requesting services does not currently have a PCSP, a PCSP shall be completed within 30 days of approval for waiver access.
- Behavior assessment, behavior support plan, or behavior management plan as applicable
- Law enforcement or DCF documentation for requests based on ANE
  Note: Documentation on ANE substantiated by DCF will be provided to the appropriate CDDO by KDADS Program Integrity.
- CDDO crisis review documentation from the CDDO crisis review committee
- Documentation that community resources have been exhausted prior to submission of crisis to KDADS
- Member's or the member representative's signature of consent for crisis request
- Any documentation available from the MCO, if applicable, pertinent to rendering a determination for a crisis request

Updated 12/16

Exception Requests

Exceptions may be provided to persons in the following situations:

- Persons in the custody of DCF may access I/DD waiver program services for the purpose of addressing non-supervision support needs related specifically to a person's I/DD diagnosis. In the event services are provided, the services shall not duplicate services already being provided, or services that should be provided, by the foster parent
- Persons who have been determined to be at imminent risk of coming into the custody of DCF.
  Note: In such cases, services shall be provided to help ensure the person avoids DCF custody. Documentation from DCF or the courts will be required to justify this exception.
- Persons under the age of 18 transitioning from DCF custody
  Note: Documentation from DCF or the courts will be required to justify this exception.
- Persons transitioning from DCF custody age 18 or older
  Note: Documentation from DCF or the courts will be required to justify this exception.
- Persons transitioning from Vocational Rehabilitation Services (VRS) which require ongoing support to maintain employment and self-sufficiency
  Note: Documentation from VRS will be required to justify this exception.
- Persons meeting the criteria set forth in the KDADS "Military Inclusion" policy
  Note: Refer to the Military Inclusion policy for documentation requirements.
- Persons transferring from a psychiatric residential treatment facility (PRTF)
  Note: Documentation of the impending transfer from the PRTF will be required to justify this exception.
- Persons previously on the I/DD waiver transferring back to the I/DD waiver from the WORK program

Transitions to the I/DD Waiver

The following HCBS programs shall transition to the HCBS I/DD waiver program if they meet HCBS I/DD functional eligibility:

- Persons determined no longer eligible for the HCBS Brain Injury (BI) waiver
- Persons determined no longer eligible for the HCBS Technology Assisted (TA) waiver
- Children determined no longer eligible for the HCBS Autism waiver
- Persons accessing services through the MFP program

Note: Upon approval by KDADS, an exception can be made when it is determined that the I/DD waiver is the most appropriate considering the person's health and safety.

Procedures

Crisis Exception Request Process

Requests to CDDO

- The person or person's representative requests a crisis or exception to the CDDO.
- Prior to submission of a crisis or exception request, the person must have a current functional assessment on file performed within the past 365 days.
- The CDDO completes and obtains all required and applicable documentation required for the request in accordance with KDADS policy.
- The CDDO crisis review team recommends approval or denial of the request.
    - If the request is approved, all documentation will be forwarded to KDADS through the IDD Utility Upload tool.
    - If the request is denied, the CDDO will provide notification with appeal rights.
- If the denial is appealed, the CDDO will follow their local dispute resolution process consistent with K.A.R. 30-64-32 and render a written decision within 20 days. The committee reviewing the appeal shall not consist of the same membership of the original crisis review team. Upon completion of the secondary review the following will occur.
    - If the denial is reversed, the CDDO shall submit the crisis request and supporting documentation to KDADS through the IDD Utility Upload tool.
    - If the denial is upheld, the CDDO shall provide notice of the decision and appeal rights, consistent with K.A.R 30-64-32, to the person, family (if applicable), DCF (if the person is in the custody of DCF), the TCM (if applicable) and the MCO.
- Copies of the request and denial will be provided to the MCO.
- If the denial is appealed again, all documentation, including both denial determinations, will be provided to KDADS for review and will then follow the KDADS review process.

KDADS Review Process

Request Review

- The I/DD program manager reviews all uploaded documentation provided by the CDDO.
- All documentation will be reviewed within 10 business days.
- Crisis requests will not be considered until all required supporting documentation has been uploaded into the KDADS IDD Utility Upload tool.

Determination

- Approval or denial documentation will be mailed to the address on file and emailed to the CDDO, DCF (if the person is in the custody of DCF), and MCO, if applicable. Form 3160 shall be completed and forwarded for all approvals.
- If the request is denied:
    - KDADS will provide the person and/or guardian, CDDO, MCO (if applicable), and DCF (if the person is in the custody of DCF) with a formal NOA indicating the services were denied and providing the person with their appeal rights.
    - The person/parent/guardian may request administrative reconsideration of the crisis denial by submitting a reconsideration request, within 30 days, and providing additional documentation to KDADS.

Updated 05/16

KDADS Review continued

Approval

- KDADS communicates its approval to the Kansas Department of Health and Environment (KDHE) Clearinghouse, CDDO, and MCO through the ES-3160.
- The KDADS I/DD program manager sends a NOA approval to the person. A copy is also emailed to the CDDO and MCO, if applicable.

Transition to the I/DD Waiver Program

The following HCBS programs shall transition to HCBS I/DD wavier program if they meet HCBS I/DD functional eligibility.

- Person is determined no longer eligible for the TA, Autism, or BI waiver programs.
- The respective program manager sends an NOA to the person of their ineligibility. The I/DD waiver program manager, MCO, and DCF (for persons in the custody of DCF) are emailed a copy of the NOA.
- The I/DD waiver program manager coordinates with the CDDO to determine if the person is eligible to transition to the I/DD waiver program.
- If a person is eligible for the I/DD waiver program, a functional assessment is scheduled if current assessment is more than 365 days old.
- Upon completion of the functional assessment, the CDDO will notify the I/DD program manager and MCO of the functional eligibility determination.
- Upon functional eligibility determination, the I/DD waiver program manager sends the NOA for the I/DD waiver program to the person. For children in the custody of the Secretary of DCF, the NOA shall also be forwarded to DCF.
- Form 3160 is sent to the CDDO, KDHE Clearinghouse, and MCO. I/DD services must begin within 45 days of issuances of Form 3160.

Documentation and Quality Assurance

- The CDDO shall submit a quarterly report to KDADS by the 20th of the quarter due. This report will be sent to the HCBS-KS@kdads.ks.gov mailbox with the subject line [INSERT APPROPRIATE quarter AND YEAR] [INSERT CDDO] Crisis Request Report.
  Example: Quarter 1 2016 ABC CDDO Crisis Request Report.
- This report shall include the following information:
  - Total number of crisis requests submitted to the CDDO during the quarter
  - Total number of crisis requests submitted KDADS for review
  - Total number of crisis requests returned by KDADS to CDDO for more information
  - Total number of crisis requests denied by CDDO

INTRODUCTION TO THE HCBS I/DD PROGRAM

Updated 11/17

HCBS Access for Individuals in the Custody of DCF

- Any child determined eligible for HCBS I/DD waiver services who the court has found to be a child in need of care (CINC), has come into custody of the Secretary of DCF, and placed in a foster care living arrangement will not be placed on a waiting list and shall have access to the services required to meet their assessed needs. The approved HCBS I/DD services will not duplicate services available through other resources.
- 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 KDADS upon consultation with DCF and other applicable authorities. Therefore, the HCBS Program Manager will consult with the DCF Permanency Program Administrator and MCO prior to approving an exception for member-directed services.
    - For individuals receiving HCBS I/DD waiver services, the CDDO servicing the child's current county of residence notifies KDADS if, upon investigation, it is determined agency-directed services are not available in the geographic area where the child is currently placed. The CDDO also notifies the home county CDDO (i.e. county where the CINC case originated and is assigned as the primary organization in KAMIS). The CDDO servicing the child currently shall notify KDADS and the home county CDDO the same day the determination is made that agency-directed services are not available.
    - Within one business day of receipt of notification, KDADS verifies that agency-directed services are not available.
    - Within two business days of receipt of notification, KDADS provides a written exception allowing member direction pursuant to section D of this policy to both the residence and home county CDDOs, including established timelines for review and renewal of the exception.
    - The child's MCO works in coordination with DCF and the child placing agency to develop a POC that includes member direction.
    - The residence county CDDO works with the child's MCO to develop agency-directed capacity.
    - The residence county CDDO arranges for transfer to an agency-directed provider as soon as capacity is created and, in turn, notifies the home county CDDO, KDADS, the Permanency Program Administrator at DCF, and the child's MCO.

Member Direction for Individuals in DCF Custody 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. For I/DD waiver members, service providers are required to be affiliated with the CDDO providing services to the member. The CDDO providing services to the member is also responsible for completion of the Service Provider Choice Form and providing a completed copy of the form to the home county CDDO and the assigned MCO. 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.

- 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.

HCBS I/DD Program services are designed to prevent members from entering, or remaining, in an ICF-I/ID.

Documenting Using "Notes" in AuthentiCare Kansas

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

- The person requesting the adjustment
- Specifically, what is being adjusted (clock in at 10:35 a.m. added, activity codes for bathing added and toileting removed, etc.)
- Reason for the adjustment (started shopping outside of home, forgot to clock in/out, etc.)
- If the adjustment was confirmed with the member

Updated 05/16

HIPAA compliance

As a member in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services 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. Providers are required to furnish the Department of Health and Human Services all information required during its review and investigation. The provider is required to provide 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.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider must not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. HCBS I/DD BILLING INSTRUCTIONS Updated 02/26

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 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.

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

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

- Sending a KanCare paper claim to KMAP
- A CMS-1500 Claim Form carbon copy
- Using a PO Box in the service location field

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, KS 66601-3571

All claims for the following self-directed services must be submitted through the EV&M system, AuthentiCare Kansas web application.

- Overnight Respite
- Personal Care Services
- Enhanced Care Services
- Specialized Medical Care (RN)
- Specialized Medical Care (LPN)
- Financial Management Services

7010. HCBS I/DD SPECIFIC BILLING INFORMATION Updated 05/26

ASSISTIVE SERVICES
Enter procedure code **S5165** in field 24D of the CMS-1500 Claim Form.
One unit equals one service.

DAY SUPPORTS
Enter procedure code **T2021** in field 24D of the CMS-1500 Claim Form.
One unit equals 15 minutes.

ENHANCED CARE SERVICES
For Agency-directed services, enter procedure code **T2025** in field 24D of the CMS-1500 Claim Form.
For Self-directed services, enter procedure code **T2025U1** in field 24D of the CMS-1500 Claim Form.
Note: Effective with dates of service on or after July 1, 2026, Self-directed Enhanced Care Services must be billed with modifier U1.
One unit is a minimum of six hours.

MEDICAL ALERT
Enter procedure code **S5161** in field 24D of the CMS-1500 Claim Form.
One unit equals one month.

OVERNIGHT RESPITE
Enter procedure code **H0045** in Field 24D on the CMS-1500 Claim Form.
One unit equals one day.

PERSONAL CARE SERVICES
Enter procedure code **T1019** in field 24D of the CMS-1500 Claim Form.
One unit equals 15 minutes.

RESIDENTIAL SUPPORTS
Enter procedure code **T2016** in field 24D of the CMS-1500 Claim Form.
One unit equals one day.

SPECIALIZED MEDICAL CARE
Enter procedure code **T1000** in field 24D of the CMS-1500 Claim Form for a licensed practical nurse (LPN) and/or registered nurse (RN).
Note: For service dates prior to May 1, 2025, the modifier TD was allowed to bill with T1000 for the RN services.
One unit equals 15 minutes.

SUPPORTED EMPLOYMENT
Enter procedure code **H2023** in field 24D of the CMS-1500 Claim Form.
One unit equals 15 minutes.

SUPPORTIVE HOME CARE
Enter procedure code **S5125** in field 24D of the CMS-1500 Claim Form.
One unit equals 15 minutes.

7010. HCBS I/DD SPECIFIC BILLING INFORMATION Updated 05/25

WELLNESS MONITORING

Enter procedure code **S5190** in field 24D of the CMS-1500 Claim Form when service is provided in an individual setting.
Enter procedure code **S5190 with modifier UA** in field 24D of the CMS-1500 when Wellness Monitoring service is provided in a congregate setting.
One unit equals one visit per 60 days.

Client Obligation

If client obligation has been assigned to a particular provider and this provider has been informed that he or she is to collect this portion of the cost of service from the client, the provider should 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
- 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.

One Plan of Care per Month

Prior authorizations through the POC process are approved for one month only. Dates of service (DOS) that span two months must be billed on two separate claims.
Example: Services for July 28 - August 3 must be billed with July 28 - 31 on one claim and August 1 - 3 on a second claim.

Overlapping Dates of Service

The dates of service on the claim must match the dates approved on the POC and cannot overlap. For example, there are two lines on the POC with the following dates of service, July 1 - 15 and July 16 - 31. If billing service dates of July 8 - 16, the claim would deny because the billed dates cross POC segments. For the first service line, any date that falls between July 1 and July 15 will prevent the claim from denying for date of service.

Same Day Service

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

- Services provided the date of admission, if provided prior to admission
- Services provided the date of discharge, if provided following discharge

7020. HCBS I/DD FINAL RULE MONITORING AND COMPLIANCE Updated 10/24

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© (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, S5125 U1
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 Kansas Department for Aging and Disability Services (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 I/DD 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 I/DD 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 members 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:
      - Kansas Aging Management Information System (KAMIS)
      - KMMS
      - Medicaid Management Information System (MMIS)
      - Quality Review Tracker (QRT)
      - 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 members' 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 member 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 member's signature;
      b) The use of the member's signature stamp and/or;
      c) The use of an identified designated signatory.
   3. If a member 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.
   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.

Quality Assurance Procedures continued

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 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 member 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. Member 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 (IDD);
      d) HCBS LOC Review: Required Documentation for QA Reviews (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 member 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/RN Statement (if applicable);
      d) Legal representative, DPOA, and/or guardianship paperwork
      e) Physical exam;
      f) Evidence of rights and responsibilities discussed with member and/or representative/guardian;
      g) Evidence of appeal and grievance rights/processes discussed with member 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 I/DD 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.

7040. HCBS I/DD ELECTRONIC VISIT VERIFICATION Updated 09/25

Ordering Provider Responsibilities
MCOs must ensure that all authorizations for HCBS subject to EVV include the appropriate ordering provider information, regardless of provider type (05 or 55).

MCOs must include the ordering provider's first name, last name and National Provider Identifier (NPI) from CMS Form 485 (Form 485) in the authorization submitted to AuthentiCare.

If Form 485 is unavailable, the member's primary care provider or discharging physician may be used temporarily.

Diagnosis Code
MCOs must use the diagnosis code listed on Form 485. If Form 485 is unavailable, use R68.89 as the standard HCBS EVV diagnosis code.

Flexibility for Oversight
For EVV compliance, the authorization must include a provider who appropriately oversees the service plan within their professional scope. This may include a physician, primary care provider, discharging physician, or supervising therapist, depending on the service provided.

MCOs must follow these guidelines only in the context of authorization submission for EVV compliance. Any necessary clinical oversight or regulatory determinations remain the responsibility of providers in accordance with existing regulations.

The following HCBS codes require an ordering provider on the EVV authorization:

Waiver	Service	Code	EVV Code
IDD	Specialized Medical Care	T1000	HCDDT1000

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 11/16

ASSISTIVE SERVICES

Assistive services are supports or items that meet a member's assessed need by improving and promoting the person's health, independence, productivity, or integration into the community. They are directly related to the member's PCSP with measurable outcomes. Examples include, but are not limited to, wheelchair modifications, ramps, lifts, modifications to bathrooms and kitchens (specifically related to accessibility), and assistive technology (items that improve communication, mobility, or assist with activities of daily living or instrumental activities of daily living in the home and workplace).

The assistive service must do one of the following:

- Increase the member's ability to live independently
- Increase or enhance the member's productivity
- Improve the member's health and welfare

ASSISTIVE SERVICES LIMITATIONS

General Limitations

- HCBS I/DD Assistive Services are available to Medicaid members who:
  - Are five years of age or older
  - Are intellectually or otherwise developmentally disabled
  - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
  - Choose to receive HCBS I/DD rather than ICF-I/ID services
- HCBS I/DD program services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through requirements relating to the deeming of parental income and who meet the criteria above.
- All assistive services must be purchased under the member's or respective guardian's written authority, must be paid to either the CDDO or an entity qualified by the CDDO, and must not exceed the prior authorized purchase amount.
- Purchase or rental of used assistive technology is limited to those items not covered through regular Medicaid.
- An outside party cannot be required to subsidize an assistive service request. The contractor must accept full payment from Medicaid.
- Up to a maximum of $300 per calendar year may be approved for the maintenance or repair of an item previously purchased through an Assistive Service.

Specific Limitations for Wheelchair Modifications

- Any wheelchair modification must be authorized by a registered physical therapist, identified as medically necessary (K.A.R. 30-5-58) by a physician and identified on the member's POC.
- This service can only be accessed after a member is no longer eligible for KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) services through the medical card.
- Wheelchair modifications must be specific to the individual member's needs and not utilized as general agency equipment.

ASSISTIVE SERVICES continued

Specific Limitations for Van Lifts (including repair and maintenance)

- Van lifts purchased must meet any engineering and safety standards recognized by the secretary of the U.S. Department of Transportation.
- Van lifts can only be installed in family vehicles or vehicles owned or leased by the member. A van lift must not be installed in an agency vehicle unless an informed exception is made by the Kansas Department for Aging and Disability Services - Community Services and Programs (KDADS-CSP).

Specific Limitations for Communication Devices

- Communication devices will only be purchased when recommended by a speech pathologist.
- Communication devices can only be accessed after a member is no longer eligible to receive services through the local education system.
- Communication devices are purchased for use by the individual member only not for use as agency equipment.

Specific Limitations for Home Modifications

- Home modifications must not increase the finished square footage of an existing structure.
- Home modifications must not be accessed for new construction.
- Home modifications must be used on property the member leases or owns, or in the family home if still living there, but not on agency owned and operated property unless an informed exception is made by KDADS-CSP.

Signature Limitations

When choosing the self-directed option, the expectation is that the member provides oversight and accountability for those providing services. Signature options are provided knowing the member may have limitations. A designated signatory can be anyone aware of the services provided. However, 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 the services received and the time recorded. Approved signing options include:

- 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 must establish, document, and monitor a plan based on the situation.

ASSISTIVE SERVICES PROVIDER REQUIREMENTS

- All providers must be State of Kansas enrolled Medicaid providers.
- Members will be permitted to purchase assistive service item(s) from any available agency in their community who is either a CDDO, an agency qualified by the CDDO, or an affiliate of the CDDO. The specified item must be provided as identified in the PCSP.

ASSISTIVE SERVICES continued

- Agencies contracted to provide home modifications include contractors and/or agencies licensed by the county or city in which they work (if required by the county or city), and they must perform all work according to existing local building codes.
- Assistive services require at least two bids from companies qualified by or affiliated with the CDDO. The bids must be submitted and reviewed prior to the approval of the prior authorization.
- All assistive services must have prior authorization. The member or responsible party must arrange for the purchase. Work must not be initiated until approval has been obtained through prior authorization.
  Note: Responsible party is defined as the member's guardian or someone appointed by the member or guardian who is not a paid provider of services for the member.

ASSISTIVE SERVICES DOCUMENTATION REQUIREMENTS

- Record-keeping responsibilities rest primarily with the Medicaid-enrolled provider.
- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
  - Copy of the receipt identifying that the service was provided
  - Name of the business or contractor
  - Identification of the service being provided
  - Date of service (MM/DD/YY)
  - Amount of purchase
  - Member's first and last name and signature (see Signature Limitations)
    Note: Regardless of who signs it, the member's name must be on the form.
  - Statement of inspection by provider to ensure product was purchased or installed as authorized
- Documentation must include a brief description of the service provided. Certain responsibilities may be passed to performing providers of the service.
- Documentation must be created during the time period of the billing cycle. Creating documentation after this time 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 07/25

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).

Key Implementation Guidelines:

Eligibility and Access:
Assistive Services must be identified in the Person-Centered Service Plan (PCSP) and authorized by the MCO. Assessment and discussion of needs should occur:

- At waiver initiation
- When the participant experiences a change in condition
- At participant request
- During PCSP reviews

Timely Evaluation:

- Needs must be evaluated within 14 business days of notification.
- Facility discharge planning must begin no later than 30 days prior to discharge.

Spending Cap:

- Combined spending for HEMS, VMS, and SMES is capped at $10,000 per lifetime, per waiver (except for I/DD waiver participants).
- Exceeding this cap requires a **Benefit Exception Report Form** submitted by the MCO.

Provider Engagement and Oversight:

- Providers must deliver bids for HEMS within 10 business days of assessment.
- MCOs are responsible for oversight, documentation, and training related to assistive services.

Quality Assurance and Training:

- All services must be documented, functional, and affirmed by the participant and care team.
- Ongoing training and maintenance are essential components and may be accessed via State Plan or waiver services.

8400. BENEFITS AND LIMITATIONS Updated 07/25

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

Grievance and Tribal Provisions:

- Participants may file grievances through the standard process or with the KanCare Ombudsman.
- Tribal participants may opt for direct service from a recognized Tribal provider with a separate provider agreement.

Action Required:

- All stakeholders must ensure they are following the revised policy procedures.
- MCOs must update staff training and procedures accordingly.
- Providers must ensure timely service delivery and documentation compliance.

For complete guidance on HCBS Assistive Services: HEMS, VMS, SMES policy – please refer to the official policy available under the "General" section on the Kansas Department for Aging and Disability Services (KDADS) website at KDADS Policies.

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 07/25

CHILDREN'S INTEGRATED COMMUNITY SUPPORTS (CHICS):

The new personal care waiver service, CHICS, will be added to the I/DD waiver as defined below:

Procedure Code	Ratio	Unit Definition
S5125 U1	1:3	15 minutes
S5125 U2	1:2	15 minutes

Note: The CHICS waiver service is subject to EVV compliance and process requirements.

CHICS is designed to provide group-based care and oversight for school-aged participants with I/DDs. Children with I/DD from aged 5 to school-leaving age often require specialized group care and supervision. This service offers a support system for families where standard childcare options do not sufficiently support their children's unique developmental needs while also allowing an opportunity for integrated care with non-disabled child peers. Traditional childcare providers do not offer the supports needed to care for children with I/DD. Direct support professionals (DSPs) provide and offer a wide variety of supports/activities that are not accessible in the child's home or in a childcare setting. CHICS offers the care provided from a direct support professional but with the addition of peer-to-peer interaction and socialization. DSPs are available to assist with ADLs and behavioral supports throughout the day. Because of different individual levels of care, 1:1 staffing is not always needed. Staffing is determined according to the specific, assessed needs of each child. The supports that are provided are necessary to ensure the health, safety, and wellness of all persons involved. CHICS creates an environment that mimics the experience a typically developing child would receive if they did not require extraordinary care. The scope, duration, and number of services authorized by the MCOs shall be consistent with the participant's assessed need as documented in the PCSP.

CHICS includes support for the participant in the following areas:

1. ADLs in accordance with K.A.R. 30-5-300.
2. IADLs in accordance with K.S.A 65-5115, K.A.R. 28-51-113, and K.A.R. 30-5-300.
3. Supervision to provide for the health, safety, and welfare of the participant.
4. Assistance and accompaniment for exercise, socialization, and recreational activities
5. Assistance accessing medical care.

CHICS serves participants when it is determined and documented within the PCSP to meet the child's needs and that the needs of each individual in the group can be safely met. The intention of this service is to provide specialized care and socialization for children with intellectual and developmental disabilities, addressing needs beyond the range of activities that a typical, licensed childcare center would perform. This extraordinary care is necessary to assure the health and welfare of the individual. Payments for CHICS cover Activities of Daily Living (ADLs), Independent Activities of Daily Living (IADLs), and other disability-related supports as documented in the PCSP. Parents or legal guardians are responsible for the general cost of standard childcare, while waiver funds for this service are specifically allocated for the additional, extraordinary care required due to the child's disability. This service provides the opportunity for Participants to receive a supporting service without the necessity of a 1:1 caregiver to participant ratio.

CHILDREN'S INTEGRATED COMMUNITY SUPPORTS (CHICS) continued

Authorization and Service Planning:
MCOs are expected to collaborate with waiver participants, their families, Targeted Case Managers (TCMs), and CHICS providers to determine the appropriate service ration and billing modifier. This collaboration must occur prior to service authorization and should ensure that the participant's needs, preferences, and circumstances are reflected in the person-centered service plan, in accordance with program guidelines.

Instructions and Limitations:

- CHICS is an agency-directed service only.
- Services are limited to 16 units per day on school days.
- Services are limited to 32 units per day on non-school days.
- Limitations are monitored through the Prior Authorization process.
- Unit exceptions may be granted based on the child's disability needs or unique family circumstances if those needs are clearly documented in the child's PCSP.

This service is exclusively delivered in a group setting. Each child is part of a group with up to two other individuals, which may include children without disabilities. Reimbursement, however, is limited to participants of the HCBS I/DD waiver. The cost associated with the provider traveling to deliver this service is included in the rate paid to the provider. Non-emergency Medical Transportation (NEMT) is a State Plan service and can be accessed through the MCO.

The service must occur in an integrated home or community location, including anywhere the person socializes. CHICS cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services, or for transition services as outlined in the participant's IEP.

Not Covered:

- Services furnished to an individual who is an inpatient or resident of a hospital, Nursing Facility (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), or Institution for Mental Disease (IMD).
- Prevocational, educational services, or supported employment services available to the participant through a local educational agency under the Individuals with Disabilities Act (IDEA) or the Rehabilitation Act of 1973.

A CHICS worker may not perform any duties not delegated by the participant or participant's representative with the authority to direct services or duties as approved by the participant's physician. The CHICS worker's task(s) must be identified as an authorized task or tasks as per the participant's authorized PCSP.

CHILDREN'S INTEGRATED COMMUNITY SUPPORTS (CHICS) continued

The services under the I/DD waiver are limited to services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Waiver funding shall be the funding source of last resort and requires a Prior Authorization from the MCO via the participant's PCSP. Service plans for which it is determined that the provisions of CHICS would be a duplication of services will not be approved. CHICS shall not be authorized for the times a participant has Residential or Day supports authorized in the participant's PCSP.

All HCBS providers are required to pass background checks consistent with the KDADS Background Check Policy and comply with all regulations related to Abuse, Neglect, and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Requirements to provide this service shall mirror those the PT/PS of 55/365:

1. Home Health Agency License.
2. Affiliated with the CDDO where the participant lives.
3. Enrolled in the KMAP.
4. Contracted with a KanCare MCO or be an approved out-of-network provider.

8400. BENEFITS AND LIMITATIONS Updated 11/17

DAY SUPPORTS

Day supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence or integration, and participation in the community. Day supports also include the provision of prevocational services which are aimed at preparing a member for paid or unpaid employment but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Activities must be in accordance with the lifestyle choices specified in the member's PCSP. These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency, and resource identification and acquisition.

DAY SUPPORTS PROVIDER REQUIREMENTS

A provider of HCBS I/DD Day Supports must be a recognized CDDO or an affiliate, as well as licensed by the Kansas Department for Aging and Disability Services (KDADS) to provide this service.

DAY SUPPORTS LIMITATIONS

- HCBS I/DD Day Supports is available to Medicaid program members who:
    - Are 18 years of age or older
      Note: In rare circumstances, a person who is under 18 years of age with extenuating circumstances may receive services if specifically approved in writing by KDADS.
    - Are determined eligible for I/DD services
    - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD screening)
    - Choose to receive HCBS I/DD rather than ICF-IID services
- HCBS I/DD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF-IID.
- Transportation costs are not covered by this service.
- Persons eligible for services through the local education authority do not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before 22 years of age, and a transition plan is developed by a transition team that includes the CDDO's representative or the CDDO's designee.
- Supported employment must be provided away from the member's place of residence.
- Supported employment activities cannot be provided until the member has applied to the local Rehabilitation Services office. The HCBS I/DD program will fund supported employment activities until the point in time when Rehabilitation Services funding for the supported employment begins. Coverage of employment-related activities under the waiver will be suspended until the case is closed by Rehabilitation Services.
- If the member is determined ineligible for vocational training through Rehabilitation Services under Section 110 of the Rehabilitation Act of 1973, then this service can be provided as a waiver service. Documentation of this determination must be maintained in the member's file.
- MCO care coordinators are responsible for ensuring that vocational rehabilitation services are NOT being duplicated for waiver members.

DAY SUPPORTS continued

To receive reimbursement (five of seven days a week):

- It is the desired outcome of KDADS-CSP that members receiving Day Supports have the opportunity to receive such services consistent with their preferred lifestyle a minimum of 25 hours per week. KDADS-CSP understands each member has unique support needs, and this outcome can be met in a variety of ways.
- Members must be out of their home a minimum of five hours per day or a total of 25 hours per week unless one of the following applies:
  - A person operates a home-based business.
  - A person is unable to be out of their home due to medical necessity or significant physical limitations related to frailty which a physician has provided current, written verification for the necessity to remain in the house.
  - A person is unable to be out of his or her home due to extreme weather conditions or another extenuating circumstance occurs, and an exception is granted in writing by the KDADS HCBS program manager.
    Note: Current is within the past 185 days and must be reviewed at least every 185 days thereafter.
- Those eligible to receive services while they remain in the home must participate in activities consistent with their PCSPs. These activities must replicate those which would normally occur outside the home.
- For those who prefer not to receive day supports five days a week, supporting documentation consistent with this preference must be available in their PCSPs.
- In any given month, the maximum number of reimbursable units of Day Supports is 460 units. The maximum number of reimbursable units of Day Supports during the providers' defined seven-day week is 100 units. The maximum number of reimbursable units of Day Supports for any given day is 32 units.

Exception Request for In-Home Day Supports - Medical Documentation Requirements

Effective July 1, 2026, KDADS will accept a statement from one of the following qualified medical professionals to support an exception request for In-Home Day Support:

- A physician (primary care or treating/following physician)
- Advanced Practice Registered Nurse (APRN)
- Physician's Assistant (PA)

The medical statement must be printed on official letterhead and include a dated signature with provider's credentials.

The statement must clearly document that:

- The medical professional has conducted a current review of the participant's condition; and
- The participant's current medical and physical condition is such that receiving Day Support services outside the home would place the participant's health at risk

Required Supporting Documentation

Each exception request must include the following:

- Current Person-Centered Support Plan
- Current Person-Centered Service Plan

Requests that do not include all required documentation may be delayed or denied.

DAY SUPPORTS continued

Review and Approval Requirements

- All approved exception requests will be reviewed at least every two (2) years.
- The review date will be determined based on the signature date of the medical statement.
- The exception will remain valid only until the assigned review date, based on the participant's likelihood of recovery.

To continue the exception:

- Updated documentation must be submitted prior to the next review date indicated on the In-Home Day Exception for the Medically Needy approval notice.

Following review, KDADS will issue an approval or denial notice to the Community Developmental Disabilities Organization (CDDO) and Managed Care Organization (MCO).

Temporary Bridge Payment Policy for HCBS I/DD Day and Residential Services

KDADS, in coordination with MCOs, is implementing a temporary Bridge Payment Policy to facilitate a smooth transition to a new reimbursement methodology for Day Habilitation Services (T2021) and Residential Services (T2016) under the HCBS I/DD Waiver Program.

Bridge Period:

- **Start Date:** July 1, 2025
- **End Date:** June 30, 2026

Transition Timeline:

- **Existing Waiver Participants:** Individuals currently enrolled in the HCBS I/DD waiver will continue to receive services reimbursed at their existing tiered rate throughout the bridge period. The new reimbursement methodology will be applied beginning July 1, 2026.
- **New Waiver Participants (on or after July 1, 2025):** For individuals enrolling in the waiver after this date, Day Habilitation and Residential Services will be reimbursed at a single, uniform rate as outlined below.

Bridge Period Reimbursement Rates:

The following reimbursement rates apply to new participants during the bridge period:

Service	Code and Modifier	Rate
Day Habilitation Services	T2021 UB *(per 15-minute unit)*	$4.57
Residential Services	T2016 UB *(per day)*	$141.92

Notes:

- Modifier UB must be appended to claims for the applicable services delivered to new participants.
- The rates noted in this manual are subject to future changes. Providers should check the KMAP website for the most up-to-date rates.

8400. BENEFITS AND LIMITATIONS Updated 06/25

Key Provisions:

- The tiered rate structure is temporarily suspended for new participants during the bridge period.
- A uniform, single-rate structure will be used exclusively for Day Habilitation and Residential Services provided to new waiver participants.
- Providers may submit requests for additional reimbursement in accordance with KDADS' Extraordinary Funding Policy for individuals with complex needs.
- KDADS will develop and implement a permanent rate methodology to take effect July 1, 2026, which will apply to all waiver participants.

Provider Guidance:

Providers are encouraged to:

- Ensure billing systems are updated to incorporate the UB modifier for claims during the bridge period.
- Review participant enrollment dates to determine applicable reimbursement rates.
- Monitor future provider bulletins for updates on the forthcoming permanent rate policy.

Conclusion:

This bridge payment policy promotes stability, consistency, and transparency in provider reimbursements during the transition to a data-informed, long-term rate structure. KDADS remains committed to supporting providers and ensuring equitable funding for services that enhance the quality of life for individuals with intellectual and developmental disabilities across Kansas.

DAY SUPPORTS DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must consist of an attendance record. Minimum components of an attendance record include:
    - Name of the service
    - Member’s first and last name
    - Date of service (MM/DD/YY)
    - Check mark to indicate the member received the service as defined
    - Signature of a responsible staff person verifying the information is correct
- A key to define all coding should be present on the attendance form.
- This record must be created and maintained during the timeframe covered by the document. Creating documentation after that time 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 11/17

ENHANCED CARE SERVICES

The primary purpose of Enhanced Care Services is to give overnight assistance to members living with a person who meets the definition of family or in a setting that does not meet the definition of living with family and the person has chosen to self-direct the service. The worker must be immediately available but can sleep when not needed. The duties of a worker include:

- Calling a doctor or hospital
- Providing assistance if an emergency occurs
- Turning and repositioning the member
- Assisting with peri-care and/or toileting
- Reminding the member of nighttime medication
- Administering medication when necessary

The worker does not perform any other personal care, training, or homemaker tasks.

ENHANCED CARE SERVICES LIMITATIONS

- HCBS I/DD Enhanced Care Services is available to Medicaid program members who:
    - Are five years of age or older
    - Meet the criteria for ICF-I/ID level of care as determined by the HCBS I/DD screening
    - Choose to receive HCBS I/DD rather than ICF-I/ID services
- HCBS I/DD is available to children, 5 to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- Enhanced Care Services cannot be provided to anyone who is an inpatient of a hospital, nursing facility, or ICF-I/ID.
- Enhanced Care Services cannot be provided by the member's spouse or by a parent of a member less than 18 years of age.
- Enhanced Care Services cannot be provided to members of Residential Supports.
- Enhanced Care Services is limited to members unable to be alone at night due to anticipated medical problems.
- The period of service for Enhanced Care Services is a minimum of 6 hours.
- The self-direct option may be chosen for Enhanced Care Services by the member. If the member is incapable of providing self-direction, his or her guardian, parent, or other person acting on his or her behalf may choose.
- A member can receive Enhanced Care Services from more than one worker, but no more than one worker can be paid for services at any given time of day. An Enhanced Care Services provider cannot be paid to provide services to more than one member at any given time of day.
- A statement of **medical necessity**, signed by a physician, must be on record.
- Enhanced Care Services 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:

ENHANCED CARE SERVICES continued

- 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
    - 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.

ENHANCED CARE SERVICES continued

- 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.
  - 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.

ENHANCED CARE SERVICES continued

- Self-directing members employing PCS workers who have a written physician's or RN'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 PROVIDER REQUIREMENTS

Enhanced Care Services must be provided by a CDDO, or an agency affiliated with a CDDO, who may or may not be licensed by KDADS for other purposes, who is enrolled in KMAP. Enhanced Care Services for members choosing to self-direct services must be provided by an affiliate of the CDDO who also functions as an enrolled FMS provider.

ENHANCED CARE SERVICES DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
  - Service being provided
  - Member's first and last name and signature (see Signature Limitations)
    Note: Regardless of who signs it, the member's name must be on the form.
  - Caregiver's name and signature
  - Date of service (MM/DD/YY)
  - Start time for each visit, include AM/PM or use 2400 clock hours
  - Stop time for each visit, include AM/PM or use 2400 clock hours
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.
- Documentation must be created at the time of the visit. Creating documentation after this time is not acceptable. Providers are responsible to ensure the service was provided prior to submitting claims.

Signature Limitations

When choosing the self-directed option, the expectation is that the member provides oversight and accountability for those providing services. Signature options are provided knowing the member may have limitations. A designated signatory can be anyone aware of the services provided. The individual providing the service **cannot** sign the time sheet on behalf of the member. Each time sheet must contain the signature of the member or designated signatory verifying the services received and the time recorded. Approved signing options include:

- 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 must establish, document, and monitor a plan based on the situation.

If a member refuses to sign accurate time sheets without a legitimate reason, he or she must be advised that the attendant's time may not be paid, or money may be taken back. Time sheets not reflecting accurate times and services must not be signed. Unsigned time sheets are a matter for the billing provider to address.

ENHANCED CARE SERVICES continued

SELF-DIRECTED ENHANCED CARE SERVICES DOCUMENTATION REQUIREMENTS

For Self-Directed Enhanced Care Services, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, AuthentiCare Kansas. Electronic visit verification (EVV) 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)
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the 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 (such as Self-Directed Enhanced Care Services)
- Member's name (first and last) and signature on each page of documentation (see Signature Limitations)
- Worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- 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

IMPLEMENTATION OF VIRTUAL DELIVERY OF SERVICES

Effective with dates of service on or after July 1, 2025, Virtual Delivery of Services (VDS) will be authorized across all HCBS Waivers. This new policy establishes the option for certain services to be provided electronically using a HIPAA-compliant, real-time audiovisual platform that enables staff to both see and hear the participant. This initiative supports greater autonomy, access, and flexibility for individuals receiving services, while maintaining compliance with federal privacy and safety requirements.

Definition:

VDS refers to the real-time provision of supports using secure audiovisual technology. Communication methods such as text messaging or email do not qualify as VDS under this policy and will not be considered direct service delivery.

Place of Service Codes:

- **Code 02:** VDS provided outside the participant's home
- **Code 10:** VDS provided within the participant's home

Place of service must be documented in the participant's Person-Centered Service Plan (PCSP).

IMPLEMENTATION OF VIRTUAL DELIVERY OF SERVICES continued

Authorized Services and Applicable Codes:

Service	KMAP Codes
Day Habilitation	T2021
Personal Care Services – Agency	T1019
Residential Habilitation Supports for Adults	T2016
Supported Employment	H2023

Key Policy Considerations:

- **Informed Consent:** Participants or their legal representatives must sign a consent form confirming the choice between in-person and virtual service delivery, including a discussion of any potential health or safety concerns.
- **Hands-On Services:** VDS is not permitted for services requiring physical assistance.
- **Participant Choice:** VDS should not replace or discourage in-person services. Participants may switch to in-person services at any time; transition must occur within 7 days, or immediately if health/safety concerns arise.
- **Privacy:** Virtual service platforms must uphold participant privacy. Use of cameras in private spaces such as bathrooms and bedrooms is prohibited.
- **HIPAA Compliance:** All VDS must adhere to HIPAA Privacy and Security Rules.
- **Support for Technology Use:** Participants' need for assistance with VDS technology must be assessed and documented in the PCSP.
- **Service Frequency and Visit Modality:** Decisions regarding the extent and frequency of VDS, including any required in-person visits, will be determined and documented in the PCSP.

8400. BENEFITS AND LIMITATIONS Updated 11/17

MEDICAL ALERT

Medical alert and other monitoring systems provide support to the member having a medical need that could become critical at any time.

The following are examples of medical needs that might require this service:

- Quadriplegia
- Severe heart conditions
- Diabetes which is difficult to control
- Severe convulsive disorders
- Severe chronic obstructive pulmonary disease
- Head injury

Medical Alert providers dispense adult failure alarm systems which are small pieces of electronic equipment linked to the member's phone which can automatically dial three phone numbers when buttons on the instrument are pushed.

The first call is placed to a predetermined responder who answers the call for help. Ideally, the responder is a relative or friend who volunteers his or her services. However, it may be considered part of the MCO care coordinator's duties. The second call should be to a physician, and the third to a medical emergency unit or center.

The adult failure system (e.g., medical alert) can be maintained for a 30-day period if a member is placed in a nursing home or a hospital for a short stay. This avoids the need to discontinue and reinstall the service which is both disruptive and costly to the patient.

MEDICAL ALERT LIMITATIONS

- HCBS I/DD Medical Alert rental is available to Medicaid program members who both:
    - Meet the criteria for the ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
    - Are determined eligible for I/DD services
- HCBS I/DD program services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria above.
- Rental, but **not** purchase, of this unit is covered.
- This service must be billed at a monthly rate.

MEDICAL ALERT ENROLLMENT

Home health agencies do not have to complete a separate provider enrollment application when providing this service.

Examples of qualified providers of this service include, but are not limited to, agencies, hospitals, and emergency transportation service companies.

MEDICAL ALERT continued

MEDICAL ALERT DOCUMENT REQUIRMENTS

- Documentation, at a minimum, must include the following:
  - Service provider's name
  - Service being provided
  - Date of invoice or statement (MM/DD/YY)
  - Member's first and last name
  - Month of coverage (MM/YY)
  - Cost of service
- Documentation must be created during the timeframe of the billing cycle. Creating documentation after this time 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 11/16

OVERNIGHT RESPITE

Overnight Respite is temporary care provided to a member to provide relief for the member's family member who serves as an unpaid primary caregiver. Respite is necessary for families who provide constant care for members. It allows family members to receive periods of relief for vacations, holidays, and scheduled periods of time off.

OVERNIGHT RESPITE LIMITATIONS

- HCBS I/DD Overnight Respite care services are available to Medicaid members who:
    - Are five years of age or older
    - Are intellectually or otherwise developmentally disabled
    - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
    - Choose to receive HCBS I/DD rather than ICF-IID services
    - Have a family member who serves as the primary caregiver who is not paid to provide any HCBS I/DD program service for the member
- HCBS I/DD Overnight Respite services are available to minor children, 5 to 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- HCBS I/DD services cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF-IID.
- Room and board costs are excluded in the cost of any HCBS I/DD waiver services except overnight facility-based respite.
- Overnight Respite may only be provided to members living with a person immediately related to the member. Immediate family members are parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any stepfamily relationships.
- Overnight Respite cannot be provided by a member's spouse or by a parent of a member-who is a minor child under 18 years of age.
- Members receiving Overnight Respite cannot also receive Residential Supports or Personal Care Services as an alternative to Residential Supports.
- A member can receive Overnight Respite services from more than one worker, but no more than one worker can be paid for services at any given time of day. An Overnight Respite provider cannot be paid to provide services to more than one member at any given time of day.
- Overnight Respite is limited to 60 days (based on an average of 5 days per month), per member, per calendar year.
- Overnight Respite is billed on a daily rate (one unit equals one day), and the services provided must meet the member's support needs.
- Overnight Respite care will be provided in the following locations and allow for staff to sleep:
    - Member's home or place of residence
    - Licensed foster home
    - Facility approved by KDHE or KDADS which is not a private residence
    - Licensed respite care facility/home

OVERNIGHT RESPITE continued

OVERNIGHT RESPITE PROVIDER REQUIREMENTS

- Providers of Overnight Respite must be affiliated with the CDDO for the area where they operate.
- Providers of overnight facility-based respite care for minor children must be licensed by KDADS or KDHE.
- Adult facility-based respite providers must be licensed by KDADS.
- A self-direct option may be chosen for Overnight Respite by the member. If the member is not capable of providing self-direction, the member's guardian or someone acting on his or her behalf may choose.

OVERNIGHT RESPITE DOCUMENTATION REQUIREMENTS FOR AGENCY-DIRECTED SERVICES

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
    - Name of service being provided
    - Member's first and last name
      Note: Regardless of who signs it, the member's name must be on the form.
    - Caregiver's name and signature
    - Date of service (MM/DD/YY)
    - Start time for each visit, include AM/PM or use 2400 clock hours
    - Stop time for each visit, include AM/PM or use 2400 clock hours
- Time must 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 created at the time of the visit. Creating documentation after this time is not acceptable.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

OVERNIGHT RESPITE DOCUMENTATION REQUIREMENTS FOR SELF-DIRECTED SERVICES

For self-directed Overnight Respite services, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, AuthentiCare Kansas. EVV 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)
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

OVERNIGHT RESPITE continued

For those limited instances where the 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 (ex. Self-Directed Overnight Respite)
- Member's name (first and last) and signature on each page of documentation (See Signature Limitations)
- Personal Care Services worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- 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
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked
  Note: Billing staff may round the total to the quarter hour at the end of a billing cycle. For a post payment review, reimbursement will be recouped if documentation is not complete.

Signature Limitations

For those choosing the self-directed option, the expectation is that the member provides oversight and accountability for those providing services. Due to a member's limitations, assistance may be required. A designated signatory can be anyone who is aware of the services provided. The individual providing the service **cannot** sign the time sheet on behalf of the member.

8400. BENEFITS AND LIMITATIONS Updated 11/16

PERSONAL CARE SERVICES

Personal Care Services is available to members who choose to **SELF-DIRECT** all or a portion of their services and live in one of the following types of settings:

- A setting that would otherwise be considered an adult residential setting requiring services to be provided by an entity licensed by KDADS-CSP
- A setting where the person lives with someone meeting the definition of family
  Note: Family is defined as any person immediately related to the member. Immediate-related family members are a parent (including an adoptive parent), grandparent, spouse, aunt, uncle, sister, brother, first cousin, and anyone with a step-family relationship.
- A setting where a child, 5 to 21 years of age, is in the custody of DCF but not living with someone meeting the definition of family
- A setting in which a child, 15 years of age or older, resides with a person who does not meet the definition of family and who has not been appointed the legal guardian or custodian

Personal Care Services means one or more personal assistants on an individualized (one-to-one) basis ensuring the health and welfare of the member during times when the member is not typically sleeping. It means supporting the member with the tasks typically done for or by himself or herself if he or she did not have a disability. Such services include assisting individuals in performing a variety of tasks promoting independence, productivity, and integration. This service provides necessary assistance for members both in their homes and communities.

Personal Care Services includes assisting with the following:

- Activities of daily living (ADLs): bathing, grooming, toileting, transferring, health maintenance activities (including but not limited to extension of therapies), feeding, mobility, and exercises
- Independent activities of daily living (IADLs): shopping, housecleaning (related to the member), seasonal chores, meal preparation, laundry, and financial management
- Support services (SS): socialization and recreational activities
- Assistance in obtaining necessary medical services and reporting changes in the member's condition and needs
- Accompanying or providing transportation to accomplish any of the tasks previously listed

PERSONAL CARE SERVICES REVISED LIMITATIONS

- All Personal Care Services must be arranged for, and purchased under, the member's or responsible party's written authority and paid through an enrolled Financial Management Services (FMS) provider consistent with and not exceeding the member's POC. Members are permitted to choose qualified Personal Care Services workers who have passed background checks that ensure compliance with KAR 30-63-28(f).
- Members who were receiving agency-directed services and at some point, chose to self-direct their services and then determined that they no longer wanted to self-direct their Personal Care Services will have the opportunity to receive their previously approved waiver services, without penalty.
- A Personal Care Services worker cannot perform any duties for the member that would otherwise be consistent with the Supported Employment definition, Sections 1.a & b.

PERSONAL CARE SERVICES continued

- The expectation is that waiver members who need assistance with IADL tasks should rely on informal/natural supporters for this assistance unless there are extenuating circumstances that have been documented in the PCSP.
    - For example, the PCSP defines the role of the Personal Care Services support worker as a person who is teaching the member how to perform a skill.
    - In accordance with this expectation, Personal Care Services should not be used for lawn care, snow removal, shopping, ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the member lives), and meal preparation (during the times when the person with whom the member lives would normally prepare the meal).
- Personal Care Services cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services, or for transition services as outlined in the member's Individualized Education Program (IEP). In order to verify Personal Care Services are not used as a substitute, a Personal Care Services Schedule (MR-10) or the Statewide Needs Assessment must clearly define the division of educational services and Personal Care Services. Educational services must be equal to or greater than the seven hours per day in which school is regularly in session. These hours do not have to be consecutive hours. The minimum number of hours required for kindergarten students is seven hours per day for those eligible for full-day kindergarten services and three-and-a-half hours per day for those eligible for half-day kindergarten.
- Personal Care Services can be retained up to a maximum of 14 days per calendar year, at a level consistent with the approved POC. These services are retained during times when the member is an inpatient of a hospital, nursing facility, or ICF-IID and the facility is billing Medicaid, Medicare, and/or private insurance. This is provided to assist members who self-direct their care with retaining their current Personal Care Services worker(s).
- Personal Care Services providers may be reimbursed for up to 20 hours per calendar year to allow for payment to Personal Care Services attendants to attend training opportunities which will benefit the attendant in the provision of services to the member.
- Members receiving Residential Supports **cannot** also receive Personal Care Services as an alternative for the same residential supports or any of the other family/individual supports. This does not prevent the conversion of Day Supports to Personal Care Services.
- Members receiving Day Supports **cannot** also receive Personal Care Services as an alternative for the same day supports. This does not prevent the conversion of Residential Supports to Personal Care Services.
- A member can have several Personal Care Services workers providing him or her care on a variety of days at a variety of times, but a person **cannot** have more than one Personal Care Services worker providing care at any given time. KMMS will not make payments for multiple claims filed for the same time on the same dates of service.
- In addition, the State will not approve POCs for which it is determined that the provisions of Personal Care Services would be a duplication of services already approved on the POC.

PERSONAL CARE SERVICES continued

- Personal Care Services are limited to a maximum of 12 hours per 24-hour period. The services are only for the activities described previously unless sufficient rationale is provided.
  Agency-directed and self-directed Personal Care Services can be combined to meet the member's needs, but the total combination of Personal Care Services hours cannot exceed 12 hours per 24-hour period.
- The combination of Personal Care Services, Enhanced Care Services, and other HCBS program services shall not exceed a total of 24 hours of service within a 24-hour period.

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:** 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.

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	T1019
Supportive Home Care	S5125

8400. BENEFITS AND LIMITATIONS Updated 02/17

PERSONAL CARE SERVICES PROVIDER REQUIREMENTS

- Any Personal Care Services worker providing services must be at least 16 years of age and meet the provider qualifications for providing Personal Care Services as defined in the HCBS I/DD program waiver.
- Personal Care Services being provided as a self-directed alternative to Residential Supports or Day Supports cannot be provided by the legal guardian of the member.
- Providers must be either a CDDO or an affiliate of the CDDO who also functions as an enrolled Financial Management Services provider**.**
- Consistent with K.A.R. 30-63-10, the member or the member's responsible party must maintain documentation showing that the individual Personal Care Services worker has received sufficient training to meet the member's needs. Written certification must be provided to the CDDO.
- Personal Care Services workers are required to pass background checks consistent with the KDADS background check policy and comply with all regulations related to abuse, neglect, and exploitation.

PERSONAL CARE SERVICES DOCUMENTATION REQUIREMENTS

For Personal Care Services, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, AuthentiCare Kansas. EVV 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)
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the 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 (such as Self-Directed Personal Care Services)
- Member's name (first and last) and signature on each page of documentation
- Personal Care Services worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- 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
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked

Note: Billing staff may round the total to the quarter hour at the end of a billing cycle. For a post payment review, reimbursement will be recouped if documentation is not complete.

8400. BENEFITS AND LIMITATIONS Updated 02/24

RESIDENTIAL SUPPORTS

This service is provided to members who live in a residential setting and do not live with someone meeting the definition of family. Family is defined as any person immediately related to the member of services. Immediately related family members are parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins, and any step-family relationships. This service provides assistance, acquisition, retention, and/or improvement in skills related to activities of daily living, such as, personal grooming and cleanliness, bed making and household chores, food preparation, and the social and adaptive skills necessary to enable the member to reside in a noninstitutional setting. Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than costs for modifications or adaptations to the facility as required to assure the health and safety of members or to meet the requirements of the applicable life safety code. Payment for Residential Supports does not include payments made, directly or indirectly, to members of the member's immediate family. Payments will not be made for routine care and supervision which is expected to be provided by immediate family members or for which payment is made by a source other than Medicaid. This service will not be offered in a setting with nine or more beds.

Residential Supports for *adults* is authorized for persons 18 years of age of older and is provided by entities licensed by KDADS-CSP.

Residential Supports for *children* is provided for children 5 through 21 years of age. This service is designed to serve children who are not in the custody of KDADS to avoid placement in an institution or other congregate residential setting when they cannot, for whatever reason, remain in their natural families. Residential Supports for children must occur outside the child's family home in a setting licensed by child placing agencies applying the regulations of the KDHE. No more than two children, unrelated by blood or marriage to the surrogate family, can be living in a residential supports setting for children. Residential Supports for children also must:

- Cooperate with the MCO, school district, and any consultants in designing and implementing specialized training procedures
- Actively participate in IEP development and the public school education program
- Be located in or near the community where the child's family lives

Legally married couples that are both members of HCBS I/DD waiver service, may both receive residential services in their home where they cohabitate.

RESIDENTIAL SUPPORTS LIMITATIONS

- HCBS I/DD Residential Supports is available to Medicaid members who:
    - Are five years of age or older
    - Are intellectually or otherwise developmentally disabled
    - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
    - Choose to receive HCBS I/DD rather than ICF-IID services
- HCBS I/DD is available to minor children, 5 through 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.

RESIDENTIAL SUPPORTS continued

- HCBS I/DD cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF-IID.
- Room, board, and transportation costs are excluded in the cost of any HCBS I/DD services except overnight facility-based respite.
- Members of Residential Supports cannot also receive Supportive Home Care, Personal Care Services (as an alternative to Residential Supports), Overnight Respite, or Enhanced Care Services.
- Residential Supports cannot be provided in the member's family home. However, this service may be provided to a member in his or her own home or apartment as long as the community service provider is licensed by KDADS to provide this service.
- Residential Supports for *children* cannot be provided in a home where more than two members funded with State or Medicaid money reside.
- Children who receive Residential Supports with a nonrelated family must be at least 5 but no older than 21 years of age (eligibility ends on the 22nd birthday).
- Residential Supports is paid on a daily rate where one unit equals one day.
- This service is billed on daily tiered rates.
- Specific to Residential Supports provided to children, no more than 20% of the aggregated tiered reimbursement for all members can be retained by the child-placing agency to defray administrative costs.
- In order to bill the daily rate, the member must have received an authorized residential support as defined by the HCBS I/DD waiver.
- Residential providers cannot bill for services unless a residential employee physically provides an authorized residential service. It is not necessary for the member to be present at the time all residential services are provided by the employee.
- Residential support services cannot exceed the services authorized by the POC/integrated service plan.
- Residential providers are allowed to respond to residential crisis situations as prescribed by the backup plan. A crisis is defined as a situation in which the member or member representative requests help due to them feeling unsafe, medical emergencies, mental health emergencies, and/or law enforcement involvement.

RESIDENTIAL SUPPORTS PROVIDER REQUIREMENTS

- Providers of Residential Supports for *children* must be affiliated with the CDDO for the area where they operate and be licensed by KDHE as a child-placing agency (K.A.R. 28-4-171).
- Providers of Residential Supports for *adults* must be a CDDO or affiliate that is licensed by KDADS to provide Residential Supports.
- Residential Supports for *adults* can serve no more than eight individuals in one home.
- All providers of Residential Supports must be in compliance with K.A.R. Article 30-63-21 through 30-63-30.

RESIDENTIAL SUPPORTS DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.

RESIDENTIAL SUPPORTS continued

- Documentation at a minimum must consist of an attendance record. Minimum components of an attendance record include:
    - Name of the service
    - Member's first and last name
    - Date of service (MM/DD/YY)
    - Check mark to indicate the member received the service as defined
    - Signature of a responsible staff person verifying the information is correct
- A key to define all coding should be present on the attendance form.
- This record must be created and maintained during the time period covered by the document. Creating documentation after this time 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.

It is not necessary for the member to be present at the time all residential services are provided by the employee. As defined by the HCBS-I/DD Waiver number KS.0224, Residential Supports service is defined, in part, as: **This service provides assistance, acquisition, retention and/or improvement in skills related to activities of daily living such as, but not necessarily limited to, personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.**

Given a strict interpretation of this definition, the service has two distinct parts. The first part is the purpose of support and the type of support. The tables below provide a crosswalk of the member presence requirement based on the purpose and type of support.

Table 1: Purpose of Support vs Presence Requirement

Purpose of Support	Presence Requirement
Assistance	Presence is dependent upon the support required.
Acquisition of skills	Member must be present.
Retention of skills	Member must be present.
Improvement of skills	Member must be present.

Table 2: Type of Support vs. Presence Requirement

Type of Support	Presence Requirement
Personal grooming and cleanliness	Member must be present.
Bed making and household chores	Presence is dependent upon the purpose of support identified in the ISP.
Eating	Member must be present.
Preparation of food	Presence is dependent upon the purpose of support identified in the ISP.
Other instrumental ADL	Presence is dependent upon the purpose of the support identified in the ISP.

RESIDENTIAL SUPPORTS continued

Specific Guidance

- Any support of an ADL requires the member to be present.
- Support of an IADL will be dependent upon the type of IADL support and the purpose of support identified in the member's ISP.
- Any time purpose of support is the acquisition, retention, or improvement of skills the member must be present.

SPECIALIZED MEDICAL CARE

This service provides long-term nursing support for medically fragile and technology dependent members. The required level of care must provide medical support for a member needing ongoing, daily care that would otherwise require the member to be in a hospital. The intensive medical needs of the member must be met to ensure the person can live outside of a hospital or ICF-IID. For the purpose of this waiver, a provider of Specialized Medical Care must be a RN, a licensed practical nurse (LPN) under the supervision of an RN, or another entity designated by KDADS-CSP. Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of members within the scope of the State's Nurse Practice Act.

- The service may be provided in all customary and usual community locations including where the member resides and socializes.
- It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the members.
- Specialized Medical Care does not duplicate any other Medicaid state plan service or other services available to the member at no cost.
- Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the POC.

SPECIALIZED MEDICAL CARE LIMITATIONS

- HCBS I/DD Specialized Medical Care services are available to Medicaid members who:
  - Are five years of age or older
  - Are intellectually or otherwise developmentally disabled
  - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
  - Choose to receive HCBS I/DD rather than ICF-IID services
- HCBS I/DD is available to minor children, 5 through 18 years of age, who are determined eligible for the Medicaid program through a waiver of requirements relating to the deeming of parental income and who meet the criteria outlined above.
- HCBS I/DD cannot be provided to anyone who is an inpatient of a hospital, nursing facility, or ICF-IID.
- Room, board, and transportation costs are excluded in the cost of any HCBS I/DD services except overnight facility-based respite.

SPECIALIZED MEDICAL CARE continued

SPECIALIZED MEDICAL CARE LIMITATIONS continued)

- Members of Specialized Medical Care cannot also receive Residential Supports or Personal Care Services as an alternative to Residential Supports.
- Specialized medical care services may not be provided by a member's spouse or by a parent of a member who is a minor child under 18 years of age.
- Specialized medical care services are limited to a maximum of an average of 12 hours per day or 372 hours (1488 units) per month. One unit is equal to 15 minutes.
- A member can receive specialized medical care services from more than one worker, but no more than one worker can be paid for services at any given time of day. A Specialized Medical Care provider cannot be paid to provide services to more than one member at any given time of day.

Signature Limitations

When choosing the self-directed option, the expectation is that the member provides oversight and accountability for those providing services. Signature options are provided knowing the member may have limitations. A designated signatory can be anyone aware of the services provided. However, 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 the services received and the time recorded. Approved signing options include:

- 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 must establish, document, and monitor a plan based on the situation.

If a member refuses to sign accurate time sheets without a legitimate reason, he or she must be advised that the worker's time may not be paid or money may be taken back. Time sheets not reflecting accurate times and services must not be signed. Unsigned time sheets are the responsibility of the billing provider.

SPECIALIZED MEDICAL CARE continued

SPECIALIZED MEDICAL CARE PROVIDER REQUIREMENTS

- Providers of Specialized Medical Care are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a home health agency (HHA) licensed by KDHE.
- Providers of Specialized Medical Care must be affiliated with the CDDO for the area(s) where they operate.
- All providers of Specialized Medical Care must be in compliance with K.A.R. Article 30-63-21 through 30-63-30.

SPECIALIZED MEDICAL CARE DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed. Documentation at a minimum must include the following:
    - Name of the service
    - Member's first and last name and signature (see Signature Limitations)
      Note: Regardless of who signs it, the member's name must be on the form.
    - Caregiver's name and signature (for each entry)
    - Date of service (MM/DD/YY) for each entry
    - Start time for each visit, include AM/PM or use 2400 clock hours
    - End time for each visit, include AM/PM or use 2400 clock hours
    - A brief description of duties performed for each entry
- If coding is used, a key to define all coding must be included.
- This record must be created and maintained during the time period covered by the document. Creating documentation after this time 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 11/17

SUPPORTED EMPLOYMENT

Supported Employment is competitive work in an integrated setting with on-going support services for members who have I/DD. Competitive work is defined as compensated work in accordance with the Fair Labor Standards Act. An integrated work setting is a job site that is similar to that of the general work force. Such work is supported by any activity needed to sustain paid employment by persons with disabilities.

The following supported employment activities are designed to assist members in acquiring and maintaining employment.

- Individualized assessment
- Individualized job development and placement services to create an appropriate job match for the member and the employer
- On-the-job training in skills required to perform the necessary functions of the job
- Ongoing monitoring of the member's performance on the job
- Ongoing support services necessary to ensure job retention as identified in the PCSP
- Training in related skills essential to secure and retain employment

SUPPORTED EMPLOYMENT LIMITATIONS

- HCBS I/DD Supported Employment is available to Medicaid members who:
    - Are 18 years of age or older
    - Are determined eligible for I/DD services
    - Meet the criteria for ICF-IID level of care as determined by ICF-IID (HCBS I/DD) screening
    - Choose to receive HCBS I/DD rather than ICF-IID services
- HCBS I/DD cannot be provided to anyone who is an inpatient of a hospital, nursing facility, or ICF-IID.
- Transportation costs are not covered by this service.
- Members 18 to 21 years of age who are receiving a similar service supported by an IEP cannot access this service.
- Supported Employment must be provided away from the member's place of residence.
- Supported employment services must not be provided until the member has applied to the local Rehabilitation Services office. The HCBS I/DD waiver will fund supported employment activities until Rehabilitation Service's funding for the supported employment begins. Coverage under the waiver will be suspended until the case is closed by Rehabilitation Services.
- If the member is determined ineligible for vocational training through Rehabilitation Services under Section 110 of the Rehabilitation Act of 1973, then this service can be provided as a waiver service. Documentation of this determination must be maintained in the member's file.
- The MCO care coordinators are responsible for ensuring that vocational rehabilitation services are NOT being duplicated for waiver members.

SUPPORTED EMPLOYMENT continued

SUPPORTED EMPLOYMENT PROVIDER REQUIREMENTS

A provider of I/DD Supported Employment must be a recognized CDDO or an affiliate, as well as licensed by KDADS to provide this service.

SUPPORTED EMPLOYMENT DOCUMENTATION REQUIREMENTS

- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
    - Name of the service
    - Member's first and last name
    - Date of the service (MM/DD/YY)
    - Check mark to indicate the member received the service as defined
    - Signature of a responsible staff person verifying the information is correct
- Documentation must be created during the timeframe of the billing cycle. Creating documentation after this time 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 07/17

SUPPORTIVE HOME CARE

Supportive Home Care (SHC) services are provided by an agency (not self-directed by the person receiving services) to assist a person living with someone meeting the definition of family **OR** in one of the following settings:

- A setting where a child, 5 to 21 years of age, is in the custody of DCF but not living with someone meeting the definition of family
- A setting in which a child, 15 years of age or older, resides with a person who does not meet the definition of family and who has not been appointed the legal guardian or custodian
  Note: Family is defined as any person immediately related to the member. Immediate-related family members are a parent (including an adoptive parent), grandparent, spouse, aunt, uncle, sister, brother, first cousin, and anyone with a step-family relationship.

These are individualized (one-to-one) services for members that provide direct assistance with:

- Daily living and personal adjustment
- Personal care services
- Assistance with medications that are ordinarily self-administered
- Accessing medical care
- Supervision
- Reporting changes in the member's condition and needs
- Extension of therapy services
- Ambulation and exercise
- Household services essential to health care at home or performed in conjunction with assistance in daily living (such as shopping, preparing and cleaning up meals, bathing, using appliances, dressing, feeding, making the bed, doing laundry, and cleaning the bathroom and kitchen)
- Household maintenance related to the member
  Note: The SHC worker can accompany or transport the member to accomplish any of the tasks listed above or provide supervision or support for community activities.

SUPPORTIVE HOME CARE REVISED LIMITATIONS

- SHC services cannot be provided by a member's spouse or by a parent of a member who is a minor child under 18 years of age.
- SHC members cannot also receive Residential Supports.
- SHC services cannot be provided in a school setting and cannot be used for education, as a substitute for educationally related services, or for transition services as outlined in the member's IEP. In order to verify that SHC services are not used as a substitute, an SHC Services Schedule (MR-10) or the Statewide Needs Assessment must clearly define the division of educational services and SHC services. Educational services must be equal to or greater than the seven hours per day in which school is regularly in session. These hours do not have to be consecutive hours. The minimum number of hours required for kindergarten students is seven hours per day for those eligible for full-day kindergarten services and three-and-a-half hours per day for those eligible for half-day kindergarten.

SUPPORTIVE HOME CARE continued

- SHC services are limited to a maximum of an average eight hours per day in any given month. The services are only for the activities described previously unless sufficient rationale is provided for hours in excess of an average of eight hours per day. The absolute maximum allowable Supportive Home Care is an average of twelve hours per day in any given month.
- A member can receive SHC services from more than one worker, but no more than one worker can be paid for services at any given time of day.
- SHC services cannot be provided to a member who is an inpatient of a hospital, nursing facility, or ICF-IID when the inpatient facility is billing Medicaid, Medicare, and/or private insurance.

It is the expectation that members who need assistance with IADL tasks, and who live with someone meeting the definition of family who is capable of performing the IADL tasks, should rely on these informal/natural supporters for assistance unless there are extenuating or specific circumstances that have been documented in the PCSP. For example, the PCSP defines the role of the SHC provider as a person who is teaching the member how to perform a certain skill. In accordance with this expectation, SHC services should not be used for the following:

- Lawn care
- Snow removal
- Shopping
- Ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the member lives)
- Meal preparation during the times when the person with whom the member lives would normally prepare a meal

SHC providers may be reimbursed for up to 20 hours per calendar year to allow for payment to SHC attendants to attend training opportunities which will benefit the attendant in the provision of services to the member.

A description of expectations for SHC workers must be maintained and available for review. The descriptions are subject to audit.

If services are provided to children accessing services from the Local Education Authority, a separate description of expectations for SHC workers (one for when in school and one for when not in school) may be appropriate and must also be available for review. The services provided in this waiver will in no way supplant those available through a child's IEP or IFSP or services available through Section 504 of the Rehabilitative Services Act of 1973. The descriptions are subject to audit.
As part of the POC development process, the needs of all persons receiving SHC services are limited to those times not covered by Day Supports.

SUPPORTIVE HOME CARE PROVIDER REQUIREMENTS
SHC providers must be affiliated with the CDDO for the area where they operate. As indicated in K.A.R. 30-63-10, any individual providing services must be at least 16 years of age or at least 18 years of age if a sibling of the member. All individuals providing services must receive at least 15 hours of prescribed training.

SUPPORTIVE HOME CARE continued

Any entity required to maintain a current list of the name, address, and telephone number of attendant/personal care 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.

SUPPORTIVE HOME CARE DOCUMENTATION REQUIREMENTS

- Recordkeeping responsibilities rest primarily with the Medicaid-enrolled provider.
- Written documentation is required for services provided and billed to KMAP.
- Documentation, at a minimum, must include the following:
    - Member's first and last name and signature (see Signature Limitations)
      Note: Regardless of who signs it, the member's name must be on the form.
    - Caregiver's name and signature
    - Complete date of service (MM/DD/YY)
    - Start time for each visit, include AM/PM or use 2400 clock hours
    - Stop time for each visit, include AM/PM or use 2400 clock hours
    - Brief description of duties performed
- 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.
- Documentation must be created at the time of the visit. Creating documentation after this time 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.

Signature Limitations

Signature options are provided knowing the member may have limitations. A designated signatory can be anyone aware of the services provided. However, 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 the services received and the time recorded. Approved signing options include:

- Member's signature
- Member making a distinct mark representing his or 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 must establish, document, and monitor a plan based on the situation.

If a member refuses to sign accurate time sheets without a legitimate reason, he or she must be advised that the attendant's time may not be paid, or money may be taken back. Time sheets not reflecting accurate times and services must not be signed. Unsigned time sheets are the responsibility of the billing provider.

8400. BENEFITS AND LIMITATIONS Updated 11/17

WELLNESS MONITORING

Wellness Monitoring requires an RN to evaluate the member's level of wellness. The RN determines if the member is properly using medical health services as recommended by the physician and if the member is maintaining a stable health status in his or her place of residence without frequent skilled nursing intervention. Wellness Monitoring reduces the need for routine check-ups in a costly medical care facility.

Wellness Monitoring includes checking and/or monitoring the following:

- Orientation to surroundings
- Skin characteristics
- Edema
- Personal hygiene
- Blood pressure
- Respiration
- Pulse
- Adjustments to medications

WELLNESS MONITORING LIMITATIONS

- A member eligible for Wellness Monitoring lives in a noninstitutional setting.
- The member is able to maintain independence with Wellness Monitoring visits no more than every 60 days.
- Direct medical intervention is obtained through the appropriate medical provider and is NOT funded by this program.
- Wellness Monitoring must be provided by a licensed RN in private employment or employed by a home health agency, local health department, CDDO, or affiliate.
- The RN who provides Wellness Monitoring may also provide nursing care and supervise medical attendants.
- Wellness Monitoring is not covered for HCBS I/DD members when provided within the same 60-day period as skilled nursing services provided by a home health agency.
- Only one visit by an RN, per 60 days, is covered.
  Note: Consideration will be made when documentation submitted with the claim indicates the medical need. This limitation will be monitored post pay.

WELLNESS MONITORING ENROLLMENT

Private RNs must attach a copy of their nursing license to the provider enrollment packets.

WELLNESS MONITORING DOCUMENTATION REQUIREMENTS

- The Wellness Monitoring RN must provide the MCO care coordinator with a brief written summary following each visit, indicating how the member is doing under the services currently provided. With the member's written consent, this may also be forwarded to the primary care physician as appropriate.
- Written documentation is required for services provided and billed to KMAP.

WELLNESS MONITORING continued

- Documentation, at a minimum, must include the following:
  - Member's first and last name
  - Nurse's name and signature with credentials
  - Date of service (MM/DD/YY)
  - Clinical measurements
  - Review of systems
  - Additional observations, interventions, teaching issues or other matters, as needed
- Documentation must be created at the time of the visit. Creating documentation after this time 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.

DEFINITIONS Updated 12/25

Affiliate - a local agency or individual which provides at least one service to members who are intellectually or developmentally disabled and has entered into an affiliation agreement with the recognized CDDO.

Behavior Assessment - a component of the functional eligibility assessment measuring the frequency in exhibiting certain behaviors (e.g. damages own or others property, is self-injurious, resists supervision) to determine the level and type of supervision needed to meet the individual's needs.

Behavior Support Plan - a plan that assists a member in building positive behaviors to replace or reduce a challenging/dangerous behavior. This plan may include teaching, improving communication, increasing relationships, and using clinical interventions.

Community Developmental Disability Organization (CDDO) - a local agency, specified by county government, which directly receives county mill funds and state aid and either directly and/or through a network of affiliates provides community-based services to members who are intellectually or developmentally disabled, and is formally recognized by KDADS.

Crisis Request - a request to bypass the I/DD waiting list submitted through a CDDO for persons who are in crisis or at imminent risk of crisis and whose needs can only be met through immediate access to services available through the HCBS I/DD program.

Exception Request - a request to bypass the I/DD waiting list submitted through a CDDO for preidentified groups of individuals as defined by KDADS policy.

Functional Eligibility Assessment – evaluation of the medical, adaptive, and behavioral needs and functional capacities of an individual to determine the level of care required to meet his or her needs in the least restrictive setting.

I/DD Eligibility Requirement - the individual must either have substantial limitations in present functioning that is manifested during the period from birth to age 18 years and is characterized by significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, or has a severe, chronic disability, with all of the following:

- Is attributable to a mental or physical impairment, or multiple sensory impairments, a combination of mental and physical impairments, physical and sensory impairments, mental and sensory impairments or a condition that has received a dual diagnosis of intellectual or developmental disability
- Is manifest before 22 years of age
- Is likely to continue indefinitely
- Results, in the case of a person five years of age or older, in a substantial limitation in three or more of the following areas of major life functioning: self-care; receptive and expressive language development and use; learning and adapting; mobility; self-direction; capacity for independent living; and economic self-sufficiency

DEFINITIONS Updated 12/16

- Reflects a need for a combination and sequence of special interdisciplinary or generic care, treatment, specialized communications techniques, or other services which are lifelong, or extended in duration, and are individually planned and coordinated.
- Does not include individuals who are solely and severely emotionally disturbed or seriously or persistently mentally ill or have disabilities solely as a result of the infirmities of aging.

I/DD Screening - an assessment of the adaptive needs, maladaptive behaviors, and health needs of the members who are intellectually or developmentally disabled to determine their eligibility for ICF-IID level of care.

Person-Centered Service Plan - process required by federal regulation led by the individual requiring waiver services or their representative that documenting the services, supports, and settings that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

Plan of Care (POC) - a document completed following the determination of ICF-IID eligibility, after the member elects HCBS I/DD instead of ICF-IID services. This document, subject to the approval of the HCBS I/DD program manager, must include:

- The services to be provided
- The frequency of each service
- The provider of each service
- The cost of each service

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS I/DD 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 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.

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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.

J. **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.
K. **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.
L. **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.
M. **Seclusion:** The involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving.
N. **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.
O. **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.
P. **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
Q. **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.

III. 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.

B. 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 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.

C. 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.

D. 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.

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IV. Definitions

A. **Dependent/Immediate Family Members** – As defined by the 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.