Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS
Physical Disability

Updated 06.2025

PART II
HCBS PHYSICAL DISABILITY 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 under Publications and Forms.

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

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INTRODUCTION TO THE HCBS PD PROGRAM

Updated 03/23

The Home and Community Based Services for Physical Disability (HCBS PD) waiver program is designed for Medicaid-eligible members from a minimum of 16 years to under 65 years of age who are determined physically disabled by Social Security standards. Members 65 years of age and older who meet functional criteria for nursing facility (NF) placement and disability determination by Social Security standards and were being served by the HCBS PD waiver before 65 years of age may choose to continue receiving HCBS PD services or access services through the HCBS Frail Elderly (FE) waiver.

Members with a diagnosis of Severe and Persistent Mental Illness (SPMI), Serious Emotional Disturbance (SED), or Intellectual/Developmentally Disabled (I/DD) are excluded from the HCBS PD waiver program.

Eligible members may receive the following services:

- Assistive Services
- Financial Management Services (FMS)[1]
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation
- Personal Care Services Agency-Directed
- Personal Care Services Self-Directed
- Enhanced Care Services

All HCBS PD waiver services require prior authorization through the Plan of Care (POC) process.

HCBS PD Enrollment

All HCBS PD providers must enroll in the KMAP and receive a provider number for HCBS PD services. Contact the fiscal agent for enrollment.

[1] Refer to the *HCBS Financial Management Services Fee-for-Service Provider Manual* for criteria and information.

Updated 12/16

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

Documentation Signature Limitations for All PD Services

In all situations, the expectation is that the member provides oversight and accountability for people providing services to him or her. Signature options are provided in recognition of the member's limitations which may make it necessary for him or her to be assisted in carrying out this function. A designated signatory can be anyone who is aware services were provided. The individual providing the services **cannot** sign the time sheet (if applicable) on behalf of the member.

Each time sheet (if applicable) must contain the signature of the member or designated signatory verifying that the member received the services and that the time recorded on the time sheet is accurate. The approved signing options include:

- Member's signature
- Member making a distinct mark representing his or her signature
- Member using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider establishes, documents, and monitors a plan based on the first three concepts above.

Members who refuse to sign accurate time sheets when there is not a legitimate reason should be advised that the worker's time may not be paid, or money may be taken back. Time sheets that do not reflect time and services accurately should not be signed. Unsigned time sheets are a matter for the billing provider to address.

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 (HHS) 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 HHS 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.

KMAP Audit Protocols

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

INTRODUCTION TO THE HCBS PD PROGRAM

Updated 03/23

HCBS ACCESS FOR INDIVIDUALS IN THE CUSTODY OF DCF

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

PROCEDURES

Member direction for individuals in DCF custody

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

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 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.

Related responsibilities:

The MCO is responsible for sharing information with the member about member direction of services. The FMS provider is responsible for sharing more detailed information with the member about member direction of services once the member has chosen this option and identified an enrolled provider. This information is also available from the HCBS Program Manager and KDADS Regional Field Staff.

Updated 08/17

PROCEDURES continued

- The MCO is responsible for sharing information with the member about member direction of services. The FMS provider is responsible for sharing more detailed information with the member about member direction of services once the member has chosen this option and identified an enrolled provider. This information is also available from the HCBS Program Manager and KDADS Regional Field Staff.

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

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

Note: The statutes and regulations as quoted still reference the Kansas Department of Health and Environment (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.

Updated 08/17

PROCEDURES continued

- Written notification from KDADS to DCF indicating approval or denial of the exception allowing placement of a waiver member in a foster care setting with two or more unrelated individuals.

7000. HCBS PD BILLING INSTRUCTIONS Updated 11/17

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 portal, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Information is not recognized unless submitted in the correct fields as instructed.

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

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

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

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 a 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 HCBS PD services, with the exception of Assistive Services and Home Delivered Meals, provided outside of licensed nursing, assisted living, residential health care, home plus, or boarding care facilities must be submitted through the EV&M system, AuthentiCare Kansas, web application.

7010. HCBS PD SPECIFIC BILLING INFORMATION Updated 03/24

ASSISTIVE SERVICES

Enter procedure code S5165 in Field 24D of the CMS 1500.
One unit equals one purchase.
Purchase is limited to a maximum lifetime expenditure of $7,500 per member.

HOME-DELIVERED MEALS

Enter procedure code S5170 (includes preparation per meal) in Field 24D of the CMS 1500.
One unit equals one meal, with a maximum of two meals per calendar date.

MEDICATION REMINDER SERVICES

Medication Reminder (call/alarm) – Enter procedure code S5185 in Field 24D of the CMS 1500.
One unit equals one month.

Medication Reminder/Dispenser Installation – Enter procedure code T1505 in Field 24D of the CMS 1500.
One unit equals one installation, limited to one installation per calendar year.

Medication Reminder/Dispenser – Enter procedure code T1505U6 in Field 24D of the CMS 1500.
One unit equals one calendar month.

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION

Rental of Personal Emergency Response Systems - Enter procedure code S5161 in Field 24D of the CMS 1500.
One unit equals one month.

Installation of Personal Emergency Response Systems - Enter procedure code S5160 in Field 24D of the CMS 1500.
One unit equals one installation. The allowable installation maximum is twice per calendar year.

PERSONAL CARE SERVICES AGENCY-DIRECTED AND SELF-DIRECTED

For agency-directed, enter procedure code S5125U9 in Field 24D of the CMS 1500.
For self-directed, enter procedure code S5125U6 in Field 24D of the CMS 1500.
One unit equals 15 minutes.

For personal care services provided in a licensed assisted living, residential health care, home plus, or boarding care facility, enter procedure code S5125 UA in Field 24D of the CMS 1500.
One unit equals 15 minutes.

ENHANCED CARE SERVICES

Enter procedure code T2025 in Field 24D of the CMS 1500.
One unit equals a minimum of 6 hours of Enhanced Care Services in any given 24-hour period.

7010. HCBS PD SPECIFIC BILLING INFORMATION Updated 12/16

Client Obligation

If the KanCare Clearinghouse identifies the amount of the client obligation and the MCO follows through with assignment of the client obligation to a particular provider and informs the provider they are to collect this portion of the cost of service from the client, the provider shall not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

Overlapping Dates of Service

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

Example

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

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

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

Services for multiple months should be separated and submitted on individual claims – one claim for each month of service.

Same Day Service

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

- HCBS Personal Care Services provided the date of admission, if provided prior to the member being admitted
- HCBS Personal Care Services provided the date of discharge, if provided following the member's discharge
- HCBS Enhanced Care Services provided the date of admission, if provided prior to the member being admitted
- HCBS Enhanced Care Services provided the date of discharge, if provided following the member's discharge

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

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

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

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

S5101	S5102	S5125	T2016	T2021

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

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

Providers will be required to obtain annual certification from the 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 the 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 PD 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 PD QUALITY ASSURANCE Updated 09/24

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

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

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

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

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

7030. HCBS PD QUALITY ASSURANCE Updated 09/24

HCBS Quality Assurance continued

Quality Assurance Procedures:

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

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

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

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

E. Record Submission
   1. MCO files are to be uploaded to the QRT database.
   2. LOC assessing entity must upload documents for all HCBS waivers.

Quality Assurance Procedures continued

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.
4. At the beginning of each upload period, KDADS will send out specific information regarding documentation that must be uploaded for the audit.
5. When documentation is uploaded to QRT, the MCO/assessing entity must mark the upload as "complete."
6. Documentation uploaded after the deadline will not be considered for the quality review.

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

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

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

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

Quality Assurance Procedures continued

2. Findings from file reviews will be recorded in QRT.

I. Remediation and Response Process

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

Quality Assurance Procedures continued

viii. The assessor is not on the qualified assessor list

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 FE, PD, Brain Injury (BI));
      b) HCBS LOC Review: Required Documentation for QA Reviews (Autism (AU));
      c) HCBS LOC Review: Required Documentation for QA Reviews (Intellectual/Developmental Disability (IDD));
      d) HCBS LOC Review: Required Documentation for QA Reviews (Technology Assisted (TA));
      e) HCBS LOC Review: Required Documentation for QA Reviews (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) Person-Centered Service Plan (PCSP) for current and prior PCSP to determine timeliness. The following is considered part of the individual's PCSP and is subject to review:
         i. Documentation of participant choice, as directed by the waiver;
         ii. Physical, Functional, and Behavioral Assessment;
         iii. Back up plan;
         iv. Evidence of information provided on reporting suspected abuse, neglect, and exploitation; and
         v. Goals
      c) Physician/Registered Nurse (RN) Statement (if applicable);
      d) Legal representative, DPOA, and/or guardianship paperwork
      e) Physical exam;
      f) Evidence of rights and responsibilities discussed with participant and/or representative/guardian;
      g) Evidence of appeal and grievance rights/processes discussed with participant and/or representative/guardian;
      h) Notice of Actions (for any updates or changes in Service Plans, including annual reviews and/or adverse actions);
      i) Log or case notes (inclusive of verification of services being received in the type, scope, amount, duration, and frequency specified in the Service Plan);
      j) BI Waiver only - Progress notes for Transitional Living Skills and/or Therapies.
      k) SED Only: Documentation on Critical Incidents/APS/CPS reports regarding restraints, seclusion, or other restrictive interventions and/or anything in the AIR system.

7040. HCBS PD ELECTRONIC VISIT VERIFICATION Updated 01/25

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

Claims Process

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

Provider Responsibilities

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

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

Claims Adjustments

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

8000. BENEFITS AND LIMITATIONS Updated 12/16

ASSISTIVE SERVICES

Assistive Services are those services which meet a member's assessed need by one or both of the following:

- Modifying or improving a member's home
- Providing adaptive equipment[2]

[2] Tangible equipment or hardware, such as technology assistance devices, adaptive equipment, or environmental modifications, can be substituted for Personal Care Services when it is identified as a cost-effective alternative on the member's POC.

Purchase or rental of new or used tangible equipment or hardware under the definition of this service is limited to those items not covered through regular Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation or the educational system). This service will be used only as the funding source of last resort.

Assistive Services can include:

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

ASSISTIVE SERVICES REIMBURSEMENT

Reimbursement for this service is limited to the member's assessed level of services and based on the annualized care plan.

Reimbursement for this service is one unit equals one purchase. Purchase is limited to a maximum one time, lifetime expenditure of $7,500 per member across waivers.

ASSISTIVE SERVICES LIMITATIONS

Assistive Services for the HCBS PD waiver is available, with prior authorization from the KanCare MCO, to HCBS PD waiver members for situations defined as "critical". **All** the following conditions applicable to the critical situation must be met:

- The Assistive Services purchase is critical to the remediation of the member's abuse, neglect, exploitation, or domestic violence issue.
  AND
- The Assistive Services purchase is critical to the member's ability to remain in the community.
  AND
- The Assistive Services purchase is a necessary expenditure within the first three months of the member's return to the community.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member. Refer to the PD waiver information here, and the full details on Assistive Service limitations here.

ASSISTIVE SERVICES continued

Modifications that add to the total square footage of the home are excluded from this benefit except when necessary to complete a modification. (Examples of included modifications are those made to improve an entrance/egress in a residence or to configure a bathroom to accommodate a wheelchair).

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

Home accessibility adaptations are not furnished to adapt living arrangements that are owned or leased by providers of waiver services.

ASSISTIVE SERVICES ENROLLMENT

A provider must be a Medicaid-enrolled provider. Providers of this service are contractors and agencies licensed by the county or city in which they work who perform all work according to existing building codes. All Assistive Services will be arranged by the KanCare MCO. Members will have complete access to choose any qualified provider (agency or individual).

ASSISTIVE SERVICES DOCUMENTATION REQUIREMENTS

Written documentation is required for services provided and billed to KMAP. Providers must maintain an invoice or receipt that contains:

- Name of business or contractor
- Member’s first and last name and signature
- Identification of the technology or service being provided
- Date of service (MM/DD/CCYY)
- Amount of purchase
- Statement of inspection by provider to ensure product was purchased/installed as authorized

Documentation must be completed at the time the technology or service is provided. Generating documentation after-the-fact is not acceptable.

Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment. Providers are responsible to ensure the service was provided prior to billing.

Signature Limitations

In all situations, the expectation is the member provides oversight and accountability for people providing assistive services. Signature options are provided in recognition that a member's limitations may make it necessary they be assisted in carrying out this function. A designated signatory can be anyone who is aware services were provided and was not the provider of the services in question.

8400. BENEFITS AND LIMITATIONS Updated 08/24

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS

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

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

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

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

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

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

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

Instances

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

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

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

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

8400. BENEFITS AND LIMITATIONS Updated 08/24

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.

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

- 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.
- 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

8000. BENEFITS AND LIMITATIONS Updated 12/23

HOME-DELIVERED MEALS

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

HOME-DELIVERED MEALS REIMBURSEMENT

Reimbursement for this service is one unit equals one meal, with a maximum of two meals per calendar day.

HOME-DELIVERED MEALS LIMITATIONS

- This service is limited to members who require extensive personal care services or meal preparation as supported by the member's Uniform Assessment Instrument/Long Term Care Threshold Score for meal preparation.
- This service **cannot** be maintained when a member is admitted to a NF or acute care facility for a planned brief stay not to exceed two months following the admission month in accordance with Medicaid policy.
- This service is not to be duplicative of the home-delivered meal service provided through the Older Americans Act, subject to the member meeting related age and other eligibility requirements.
- This service is available in the member's place of residence, excluding assisted living and Home Plus facilities.
- No more than two home-delivered meals will be authorized per member for any given calendar date.
- This service must be authorized in the member’s POC by their chosen KanCare MCO.

HOME-DELIVERED MEALS DOCUMENTATION

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

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

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

HOME-DELIVERED MEALS continued

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

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

HOME-DELIVERED MEALS PROVIDER REQUIREMENTS

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

MEDICATION REMINDER SERVICES

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

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

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

The member's chosen KanCare MCO authorizes the need for this service based on an underlying medical necessity.

MEDICATION REMINDER SERVICES REIMBURSEMENT

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

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

MEDICATION REMINDER SERVICES LIMITATIONS

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

MEDICATION REMINDER SERVICES continued

MEDICATION REMINDER SERVICES DOCUMENTATION

Documentation must be collected by using the EV&M system, AuthentiCare Kansas. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the HCBS waiver service being provided
- Identification of the member receiving the service(s)
- Identification of the worker providing the service(s)
- Date of service (month and year)

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

MEDICATION REMINDER SERVICES PROVIDER REQUIREMENTS

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

8000. BENEFITS AND LIMITATIONS Updated 11/17

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION

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

PERS installation is the placement of electronic PERS devices in a member's residence. PERS installation is for those certain members at high risk of institutionalization to secure help in an emergency. These members have met the assessed need of a PERS.

To avoid any overlap of services, PERS is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. HCBS PD waiver funding is used as the funding source of last resort and requires prior authorization from the member's chosen KanCare MCO.

The member's chosen KanCare MCO authorizes the need for this service based on an underlying medical or functional impairment.

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

PERSONAL EMERGENCY RESPONSE SYSTEM LIMITATIONS

Limitations to PERS services include the following:

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

PERSONAL EMERGENCY RESPONSE SYSTEM REIMBURSEMENT

Reimbursement for this service is limited to the member's assessed level of services need. This service must be reimbursed within the approved reimbursement range established by the State.

PERSONAL EMERGENCY RESPONSE SYSTEM ENROLLMENT

With member-written authorization of the purchase, all PERS will be arranged by and generally paid through the KanCare MCO. Members will have complete access to choose any qualified provider.

PERSONAL EMERGENCY RESPONSE SYSTEM PROVIDER REQUIREMENTS

Any company providing Personal Emergency Response System and installation services is qualified.

PERSONAL EMERGENCY RESPONSE SYSTEM AND INSTALLATION continued

to provide this service. Provider requirements include:

- Must be a Medicaid-enrolled provider
- Must conform to industry standards and any federal, state, and local laws and regulations that govern this service. The emergency response center must be staffed on a 24-hour/7-day-a-week basis by trained personnel.

PERSONAL EMERGENCY RESPONSE SYSTEM DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. Documentation must be collected using the EV&M system, AuthentiCare Kansas. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the HCBS waiver service being provided
- Identification of the member receiving the service(s)
- Identification of the worker providing the service(s)
- Date of service (month and year)

Documentation must be completed monthly. Generating documentation after-the-fact is not acceptable.

Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8000. BENEFITS AND LIMITATIONS Updated 12/16

PERSONAL CARE SERVICES AGENCY-DIRECTED AND SELF-DIRECTED

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

Health maintenance activities such as monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, and range of motion may be provided in accordance with K.S.A. 65-6201 (b)(2)(A).

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

- With **Personal Care Services Self-Directed**, members hire, train, and supervise their personal care services workers. FMS providers are responsible for payroll-related activities and for providing information and assistance to members to ensure that they understand the responsibilities involved with the self-direction of their personal care services worker's care.[3]
  Refer to the *HCBS Financial Management Services Fee-for-Service Provider Manual* for more information.
- With **Personal Care Services Agency-Directed**, a qualified agency that meets all related enrollment requirements manages all aspects of Personal Care Services.

Members will have complete access to choose any qualified provider who can meet their personal care service needs.

Family members can be reimbursed when providing this service.

PERSONAL CARE SERVICES LIMITATIONS

PCS is available to HCBS PD waiver members up to and including a maximum of 12 hours per 24-hour period. The combination of PCS and Enhanced Care Services (ECS) and other HCBS program services shall not exceed a total of 24 hours of service within a 24-hour period. Other service limitations include:

- Requests for accommodation to exceed the service limit are subject to MCO authorization and shall not exceed an additional six hours of PCS. Any exception to the PCS limit must be identified by and is subject KanCare MCO authorization.
- Any accommodation requests must meet one or more of the following criteria:
  - The additional request for PCS is critical to the remediation of the member's law enforcement or DCF confirmed abuse, neglect, exploitation, or domestic violence issue.
  - The additional request for PCS is critical to address a health, behavioral health, or safety need that poses an imminent risk which, if not addressed, would cause the member to be in crisis or to be admitted to an institutional setting. The member must not have other natural or paid supports available to address the identified need that present the imminent risk.

PERSONAL CARE SERVICES AGENCY-DIRECTED AND SELF-DIRECTED continued

- The request for additional time for PCS is a necessary support for the member to remain in the community within the first three months of this or her return to the community from a stay in excess of 90 days in an institution.

- Members who have an assessed need for more than 6 hours in addition to the 12 hours of PCS, and the needs cannot be met by any other HCBS service such as Personal Emergency Response Service (PERS), may have ECS authorized in conjunction with PCS.
- The cost of transportation is included in PCS. Nonemergency Medical Transportation (NEMT) is not covered as part of PCS, but if medically necessary, may be accessed through regular Medicaid and authorized by the KanCare MCO.
- The service must occur in the home or community location meeting the setting requirements as defined in the *HCBS Setting Final Rule*. Service provided in a home school setting must not be educational in purpose. Services furnished to an individual who is an inpatient or resident of a hospital, NF, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), or institution for mental disease are not covered.
- Members in state custody cannot self-direct ECS unless an exception has been granted by KDADS.

PERSONAL CARE SERVICES REIMBURSEMENT

Reimbursement for this service is limited to the member's assessed level of services need. This service must be reimbursed within the approved reimbursement range established by the State. A Medicaid member is eligible only for the number of hours as defined in his or her POC as authorized by the KanCare MCO.

- PCS shall not be reimbursed for any period of time that a member is admitted to an inpatient residential hospital, NF, or institution for mental illness.
- PCS shall not be reimbursed while a member is in an institution for a temporary stay.
- PCS can be authorized while a member lives in an assisted living facility (ALF), but the member may not self-direct services while in an ALF.
- If the member is accessing medication reminder services, PCS shall not be authorized for medication management.
- When a member elects hospice care, PCS shall not duplicate services provided under hospice. Concurrent care is subject to approval and reviews by the MCO and must not be duplicative.
- 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.
- A PCS worker shall not work or be paid for working for more than one HCBS member at the same time on the same day. Exceptions must be justified and documented by the KanCare MCO, such as two-person lift for safety issues. Approval for these services will be

given by the KanCare MCO. Medicaid non-waivered home health services for HCBS PD members require prior authorization.

- The service must occur in the home or community location meeting the setting requirements as defined in the *HCBS Setting Final Rule.* Services provided in a home school setting must not be educational in purpose. Services furnished to an individual who is an inpatient or resident of a hospital, NF, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), or institution for mental disease are not covered.

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.
- 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,

PERSONAL CARE SERVICES AGENCY-DIRECTED AND SELF-DIRECTED continued

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 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 a particular member and his or her health needs. The qualified nurse retains overall responsibility.
- Medicare-certified Home Health Agencies and state-licensed Home Health Agencies may perform medication administration and assistance in accordance with their licenses.
- Self-directing members employing PCS workers who have a written physician's or registered nurse's statement to delegate health maintenance activities, including medication administration and assistance, are responsible to supervise PCS workers and train them to administer medication according to the physician's orders.

For more information regarding conflict of interest, legally responsible individuals, Capable Person policy, and other PCS policy requirements, reference the KDADS Personal Care Services policy for all HCBS Programs (excluding SED) on the KDADS website (posted policies).

PERSONAL CARE SERVICES ENROLLMENT

All PCS consistent with and not exceeding the individuals POC will be arranged for, reviewed, and approved by the KanCare MCO's care coordinator with the member's or legally responsible party's written authorization. They are paid for through an enrolled home health agency, when services are agency-directed, or an enrolled FMS provider, when services are member-directed. Payment for services must be made within the approved reimbursement range established by the State. Members will have complete access to choose any qualified provider (agency or individual).

PERSONAL CARE SERVICES AGENCY-DIRECTED AND SELF-DIRECTED continued

Individual providers must be 18 years of age or older and shall be required to sign an Employment Service Agreement with the member-directed employer or with a Medicaid-enrolled agency providing agency-directed services. Individual providers providing services for a member-directed employer must sign an agreement with a Medicaid-enrolled FMS provider.

PERSONAL CARE SERVICES PROVIDER REQUIREMENTS

Medicaid providers who choose to provide PCS services to self-directed members must comply with the following:

- Sign an agreement with a Medicaid-enrolled FMS provider.
- Have a high school diploma or equivalent or be at least 18 years of age or older.
- Complete KDADS-approved skill training requirements.
- Complete any additional skill training needed to care of the waiver member as recommended either by the member or legal representative, qualified medical provider, or KanCare MCO.
- All PCS workers must have a background check without prohibited offenses prior to providing support services and other required background checks in accordance with the KDADS background check policy.
- In compliance with federal requirements to ensure health, safety, and welfare and to prevent fraud, waste, and abuse, PCS workers for both agency-directed and self-directed employers shall use AuthentiCare Kansas for electronic visit verification.

Any entity providing personal care services or serving as an FMS agency for PCS must maintain a current listing of the name, address, and telephone number of all providers rendering these services.

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

PERSONAL CARE SERVICES DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. Agency and self-directed services must be documented and billed through AuthentiCare Kansas to include Agency-Directed Personal Care Services, Self-Directed Personal Care Services, and FMS. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable. Providers are responsible to ensure service was provided prior to submitting claims through AuthentiCare Kansas or KMAP.

Documentation must be clearly written or spoken and self-explanatory, or reimbursement may be subject to recoupment.

In-Home Care

For a service provided outside of a licensed adult care home, documentation must be collected by using the EV&M system, AuthentiCare Kansas. Electronic visit verification documentation must, at a minimum, include the following.

AuthentiCare Kansas Documentation

- Identification of the HCBS waiver service being provided
- Identification of the member receiving the service(s)
- Identification of the PCS worker providing the service(s)
- Date of service
- Call in at start time of the service, including AM/PM or using 2400 clock hours
- Call in at end time of the service, including AM/PM or using 2400 clock hours
- Identification of the duties performed during each visit, as noted on the activity code sheet
- Using the member's telephone authorizing the use of the electronic documentation system at the start and end of service delivery

Electronic documentation of service delivery is allowed when meeting both documentation standards and signature standards as outlined above.

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 service being provided
- Member's first and last name and signature (see Signature Limitations)
- Caregiver's first and last name and signature
- 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
  Time should be totaled by actual minutes and hours worked. Billing staff can round the total to the quarter hour at the end of the billing cycle.

Assisted Living Facilities, Residential Home Care Facilities, Homes Plus, and Board and Care Facilities

Written documentation at a minimum must include the following:

- Identification of service being provided
- Member's first and last name and signature (see Signature Limitations)
- Caregiver's first and last name and signature
- Date of service (MM/DD/YY)
- Brief description of duties performed during each contact in accordance with the current service plan

Note: Billing staff can round the total to the quarter hour at the end of the billing cycle. Postpay reviews will be based on the description of services provided. Any service provided but not authorized on the Personal Care Services Worksheet and POC will be subject to recoupment.

Personal Care Services (PCS) in Congregate Settings
The PCS provided in a licensed assisted living, residential health care, home plus, or boarding care facility will be exempt from the EVV requirement with the below listed effective dates.

For service dates December 3, 2023, through March 31, 2023, S5125 U9 provided in congregate settings will be exempt from EVV requirements. Effective April 1, 2024, HCBS/PD in congregate settings will be billed using S5125 UA, which will also be exempt from EVV requirements.

Personal Care Services (PCS) in Acute Care Hospital Settings
Effective January 1, 2025, Personal Care Services (PCS) may be delivered in an acute care hospital setting under specific conditions. This change is designed to ensure continuity of essential non-medical supports for participants during short-term hospital stays, especially for individuals with behavioral, communication, or functional support needs that may not be fully addressed by hospital staff.

Conditions for PCS Delivery in Hospital Settings:
PCS may be delivered during a participant's hospital stay when the following conditions are met:

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

Authorization and Provider Requirements:

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

Personal Care Services (PCS) in Acute Care Hospital Settings continued

Documentation and Claims Submission Requirements:

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

Applicable Procedure Codes:

Service	KMAP Codes
Personal Care Services	S5125 U9, S5125 U6 (Self-directed)

Signature Limitations

In all situations, the expectation is that the member provides oversight and accountability for those providing services. Signature options are provided in recognition that a member's limitations may make assistance necessary in carrying out this function. A designated signatory can be anyone who is aware services were provided. The individual providing the services **cannot** sign the time sheet (if applicable) on behalf of the member.

Each time sheet (if applicable) must have the signature of the member or designated signatory verifying that the member received the services and that the time recorded is accurate. The approved signature options include any of the following:

- Member's signature
- Member making a distinct mark representing his or her signature
- Member using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider establishes, documents, and monitors a plan based on the first three concepts above.

Members who refuse to sign accurate time sheets (if applicable) or who refuse to allow their telephones to be used, without a legitimate reason, should be advised that the personal care services worker's time may not be paid or that money may be taken back. Time sheets not reflecting time and services accurately should not be signed.

8000. BENEFITS AND LIMITATIONS Updated 12/16

ENHANCED CARE SERVICES

Sleep Cycle Support services are now referred to as Enhanced Care Services (ECS). ECS is available to a member who demonstrates an assessed need for a minimum of 6 hours of sleep support within a 24-hour period. The assessed need cannot be met by the use of Personal Emergency Response System (PERS), informal support, or any other services such as Personal Care Services (PCS).

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

- Self-directing members or designated representatives are responsible for hiring, supervising, and terminating the employment of the PCS worker, understanding the impact of those decisions, and assuming responsibility for the results of those decisions.
- Self-directing members and agencies employing ECS workers shall comply with applicable state and federal employment laws.
- Self-directing members employing ECS workers are subject to the same quality assurance standards as other ECS providers including, but not limited to, completion of the tasks identified on the Integrated Service Plan (ISP).

ECS is designed to provide supervision and/or non-nursing physical assistance during a member's normal sleeping hours in his or her place of residence.

- ECS must be provided in the member's home or HCBS setting as approved and authorized on the ISP. Service providers must remain in the member's home for the duration of this service provision based on the member's normal sleep cycle as documented in the member's ISP.
- The ECS worker must be able to be awakened and available to provide immediate supervision or physical assistance with tasks such as toileting, transferring, mobility, and medication reminders as needed.
- The ECS provider must be able to be awakened and capable of contacting a doctor, hospital, or medical professional in the event of an emergency.
- ECS is intended to provide support during a member's normal sleep cycle and may include non-nursing help with tasks such as toileting and mobility.

ENHANCED CARE SERVICES LIMITATIONS

- Only one unit (a minimum of 6 hours is allowed within a 24-hour period).
- ECS, in combination with other HCBS services, cannot exceed 24 hours within a 24-hour period.
- ECS must not be authorized when a member resides in an ALF, residential health care facility (RHCF), residential care facility (RCF), home plus, boarding care home, or residential supports for individuals with an intellectual and developmental disability that the member has selected as a provider.
- Reimbursement of this service is provided as a flat rate. It is the responsibility of the employer to ensure adherence to all applicable labor regulations.
- Only one ECS worker can be paid for services at any given time of the day. In order to prevent payment for overlapping of services, ECS workers cannot be paid for services when another HCBS program waiver service is being provided at the same time on the same day.

ENHANCED CARE SERVICES continued

- Members in state custody cannot self-direct services unless an exception has been granted by KDADS.
- 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).

ENHANCED CARE SERVICES PROVIDER QUALIFICATIONS

- A guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest is mitigated.
- ECS cannot be provided by a member's legally responsible person (spouse or parent of a minor child) or any individual residing in the home with the member. However, exceptions may be authorized under one or more of the following conditions in accordance with the approved HCBS waivers:
    - The member lives in a rural area, in which access to a provider is beyond a 50-mile radius from the member's residence, and the relative or family member is the only provider available to meet the needs of the member.
    - The member lives alone and has a severe cognitive impairment, physical disability, or intellectual disability.
    - The individual has exhausted other support options by the MCO and without ECS would be at significant risk of institutionalization.

Self-Directed and Agency-Directed ECS Workers

- Must be 18 years of age or older, or have a high school diploma or equivalent, and meet the provider qualifications for providing ECS as defined in the HCBS program waiver
- Have the necessary training or skills to meet the needs of the member
- Have a signed agreement with a Medicaid-enrolled FMS provider, acting as an administrative agent on behalf of the member (self-directed only)
- Maintain clear background checks of KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screen
  Note: Any provider identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding

ENHANCED CARE SERVICES REIMBURSEMENT

Reimbursement for this service is limited to the member's assessed level of services need. This service must be reimbursed within the approved reimbursement range established by the State.
A Medicaid member is eligible only for the number of ECS units per month, as defined in his or her POC. Although for billing purposes a POC is authorized on a monthly basis, the total approved ECS units for a member cannot exceed the number of ECS units approved on the monthly POC.

Financial Management Services

- Members who are self-directing ECS must also receive FMS to receive the necessary information, assistance, and support with ministerial employer-related functions such as payroll and tax withholding.

ENHANCED CARE SERVICES continued

- FMS providers provide information related to state and federal rules, employer duties, and HCBS program requirements and responsibilities. FMS providers provide assistance with employer-related functions, referrals to community options, and information on the options available related to member direction.
- Refer to the *HCBS Financial Management Services (FMS) Fee-for-Services Provider Manual* for policies related to FMS.

ENHANCED CARE SERVICES DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. ECS paid for by the HCBS program are limited to the number of hours/units authorized on the ISP and in the AuthentiCare Kansas system. ECS workers, both agency-directed and self-directed, are required to use AuthentiCare Kansas. This is necessary to comply with federal requirements to ensure the health and safety of members and to prevent fraud, waste, and abuse.

- Documentation must be generated at the time of the visit. Generating documentation after-the-fact is not acceptable.
- Documentation must be clear and self-explanatory, or reimbursement may be subject to recoupment.
- Documentation must be uploaded to AuthentiCare Kansas by the FMS provider and in the member's file, as applicable.

Documentation must be collected by using the EV&M system, AuthentiCare Kansas. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of service being provided
- Member's first and last name and signature (see Signature Limitations)
- Identification of the worker
- 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

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 service being provided
- Member's first and last name and signature (see Signature Limitations)
- Caregiver's first and last name and signature
- 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

ENHANCED CARE SERVICES continued

Each time sheet (if applicable) must contain the signature of the member or designated signatory verifying that the member received the services and that the time recorded on the time sheet is accurate. The approved signing options include:

- Member's signature
- Member making a distinct mark representing his or her signature
- Member using his or her signature stamp
- Designated signatory

In situations where there is no one to serve as designated signatory, the billing provider establishes, documents, and monitors a plan based on the first three concepts above.

Time should be totaled by actual minutes/hours worked. Billing staff can round the total to the quarter hour at the end of the billing cycle.

Signature Limitations

In all situations, the expectation is that the member provides oversight and accountability for people providing services for him or her. Signature options are provided in recognition that a member's limitations make it necessary that they be assisted in carrying out this function. A designated signatory can be anyone who is aware services were provided. The individual providing the services cannot sign the time sheet on behalf of the member.

Members who refuse to allow access to their telephones, when there is not a legitimate reason, should be advised that the worker's time may not be paid, or money may be taken back. Phone calls that do not reflect time and services accurately will not be honored. If a worker fails to use the AuthentiCare Kansas system appropriately, it is a matter for the billing provider to address.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS PD SERVICES

Updated 08/24

1. Services are provided according to the POC, in a quality manner, and as authorized on the Notice of Action (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.

Updated 02/25

II. Adverse Incident Definitions

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

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

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

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

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

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

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

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

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

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.

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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 Extended Care Health Option (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 has current motor vehicle registration in Kansas
        iv. Proof eligible military personnel holds 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 Internal Revenue Service (IRS), a spouse, child, parent, brother, sister, grandparent, grandchild, step-parent, step-child, step-brother, or step-sister of the individual in the military (IRM 1.25.1.2.2) who is claimed on the military personnel's federal income tax return as a dependent qualifying widower and dependent child, qualifying child or qualifying relative as established in the IRS Publication 501.

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

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

D. **Functional Eligibility -** The process whereby a member is determined to meet the Level of Care (LOC) 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.

Waiver Program Eligibility and Waiting List Management

I. General Policy

A. The Aging and Disability Resource Center (ADRC) shall serve as the single-entry point for the HCBSPD waiver program.

B. The ADRC shall be responsible for conducting the LOC eligibility assessment for the program, including administering the functional eligibility assessment for PD program eligibility.

1. The ADRC shall perform conflict-free functional eligibility assessments

C. Individuals must meet the LOC score requirement for NF placement, as determined by the State's functional eligibility instrument, to be functionally eligible for the HCBS PD waiver program.

D. The ADRC will conduct functional eligibility assessments in accordance with the approved HCBS waiver current at the time of the assessment and this policy.

E. A functional eligibility assessment shall be conducted for every applicant of the program, and a reassessment shall be conducted annually.
    1. Functional eligibility assessment shall be performed using the state-approved functional assessment instrument.
F. A crisis exception request can be made at the time of initial assessment or at any time while on the waiting list.
G. Members who turn 65 years of age and are receiving PD waiver services have the option to continue receiving services under the program or may choose to transition to the HCBS FE program, provided they meet the established criteria.
    2. If a member wishes to transition to the FE waiver, the individual's MCO is to follow the transition process described by the HCBS Transition Policy on the KDADS website.
H. The ADRC will complete a provisional POC for individuals newly eligible to receive services in the program.

II. Eligibility Criteria

A. Applicants for the program must meet the following eligibility criteria:
    1. Be between 16 and 64 years of age
    2. Be a resident of Kansas
    3. Must show the need for assistance in performing Activities of Daily Living (ADLs) and must meet the LOC required for NF placement as determined by Medicaid Long Term Care (LTC) standards.
        a) Total LOC score of 26 or higher; and
        b) An ADL score of 6 or higher; or
        c) An Instrumental Activities of Daily Living (IADL) Score of 12 or higher. The PD Waiver Program Manager may request additional medical documentation to support a PD program eligibility determination if the ADL score is less than 6 or the IADL score is less than 12.
    4. Have a physical disability diagnosis.
    5. Be determined disabled by the Social Security Administration (SSA).
B. Not currently participating or on the waiting list of the HCBS I/DD Waiver program.
    1. Applicants with an I/DD primary diagnosis may not be eligible to be assessed for PD Waiver eligibility
        a) In the event an applicant has a primary diagnosis of I/DD, the assessor must make a referral to the Community Developmental Disability Program (CDDO), in the area which the member resides, for evaluation.
    2. Applicants who have a diagnosis of severe and persistent mental illness (SPMI), or a SED, must also show proof of a physical disability.
C. Meet Kansas Medicaid financial eligibility

III. Qualifications of ADRC Functional Eligibility Assessor

A. The ADRC is responsible for verifying functional eligibility assessor qualification, experience, education, and certification requirements.
    1. The ADRC must maintain functional eligibility assessor records for 5 years following employment termination.

B. Functional eligibility assessors for the program shall meet the following qualification requirements:
    1. Four-year degree from an accredited college or university with a major in Gerontology, Nursing, Health, Social Work, Counseling, Human Development, Family Studies, or related area as defined by the ADRC contractor, OR
        a) Must be or a Registered Nurse licensed to practice in the state of Kansas
    2. Functional eligibility assessors must complete the functional eligibility assessment instrument designated by KDADS.
        a) An assessor who has not conducted any functional assessments within 6 months must repeat the training and certification requirements for the functional eligibility assessment instrument designated by KDADS.
    3. Functional eligibility assessors must complete training in the state-designated Management Information prior to performing any functional eligibility assessment.

C. KDADS shall conduct all training sessions, certification, and recertification of the functional eligibility assessment instrument.
    1. All training and certification sessions must be documented.
    2. The ADRC shall be responsible for tracking and monitoring its assessors' training and certification.

IV. Level of Care (LOC) and Functional Eligibility Determination

A. Prior to the functional eligibility assessment, the ADRC must complete a preliminary standard intake screening that assesses for the following:
    1. Applicant age,
    2. Applicant residency, and
    3. Reasonable indicators of meeting the LOC eligibility
        a) In the event the applicant does not meet all the preliminary standard intake screening criteria, the assessor shall not continue with the PD assessment and shall take additional action to refer the individual to the appropriate resources.

B. If the individual meets the age, residency, and reasonable indicator criteria, the assessing entity shall:
    1. Schedule a face-to-face visit to assess the applicant's functional eligibility for the program.
        a) The face-to-face visit shall be conducted with the applicant as the primary source of information
        b) The assessor must provide accommodations as required under federal law and the Americans with Disabilities Act (ADA) to ensure the applicant is able to participate in the assessment process.
        c) Family members and other individuals who might have relevant information about the member may be interviewed.
    2. Verify that the applicant has the appropriate physical disability diagnosis.
        a) Applicants with a Serious and Persistent Mental Illness must also have been determined disabled by the SSA.
        b) In the event the disability diagnosis or determination does not indicate a physical disability, the assessor must notify the applicant that the state will request additional documentation to support their disability and that

any documentation provided must have relevant information to support the diagnosis of a physical disability.

C. The eligibility assessor shall conduct the functional eligibility assessment using the state-designated functional eligibility instrument.
D. Upon completion of the assessment, the assessor shall complete the following:
    1. Provide the applicant with the LOC outcome,
        a) The assessing entity shall provide the individual with a copy of their assessment upon request only.
    2. Obtain the applicant's or their legal guardian's or their activated Durable Power of Attorney for Health Care (DPOAHC) assignee's signature on the LOC outcome documentation,
    3. Complete a state-designated Release of Information (ROI) Form, and obtain the applicant's signature,
        a) The applicant, the applicant's legal guardian, or the activated DPOAHC assignee can sign the ROI.
    4. Provide a copy of the LOC outcome documentation of the applicant's assessment.

V. Functionally Eligible Determination

A. If an applicant is found functionally eligible, the assessor will:
    1. Complete a provisional POC for the functionally eligible applicant,
        a) Using the PD Provisional POC accessible on the KDADS website.
    2. The assessor shall evaluate the individual for a potential crisis exception in accordance with the PD Crisis Exception Policy.
B. The assessor shall:
    1. Proceed to upload the following documents into the KDADS designated management information system of record:
        a) A signed copy of LOC outcome documentation
        b) A signed copy of the state-designated ROI Form
        c) A copy of the PD Provisional POC form (only if the applicant is functionally eligible)
        d) ES-3160 Form notification of KanCare HCBS Services Form (completed sections I and II, indicating eligibility or ineligibility)
C. The assessor shall data enter/upload/submit the assessment, along with all the required documents to the PD Program Manager, via email or upload to the designated state management information system of record within 5 business days of completion.
    1. The PD Program Manager shall designate the preferred system of record for documents submission.
D. Upon receipt of all required documentation, the PD Program Manager will review the assessment and make a determination.
    1. If an applicant is determined eligible, the PD Program Manager shall change the applicant's status to "Active" on the program waiting list.

VI. If an applicant is NOT found functionally eligible, the assessor will:

A. Proceed to upload the following documents into the KDADS designated management information system of record:

1. A signed copy of LOC outcome documentation that includes the consumer's appeal rights and responsibilities.
2. A signed copy of the state-designated ROI Form
3. ES-3160 Notification of KanCare HCBS Services Form (completed sections I and II, indicating ineligibility)

VII. Administrative Case Management (ACM) Entity

A. The ACM entity shall assist the HCBS PD program applicant in the following:
   1. KanCare Application Assistance
      a) The ACM entity shall be the single point of contact for applicants during Medicaid application.
   2. Accessing required documentation for functional, program, and financial eligibility determinations including but not limited to the following:
      a) Proper applicable documents to support crisis exception requests for a qualifying applicant.
      b) Documentation of Social Security Disability (SSD) determination for BI, PD Waiver applicants.
      c) Proof of application of SSA disability benefits for individuals not yet determined as disabled by the SSA.
   3. Serving as a liaison between the applicant and assessing entity (ADRC) to facilitate a successful application process.

VIII. Annual Assessment

A. The ADRC shall conduct a re-evaluation for a LOC eligibility every 365 days for active PD waiver members.
   1. Annual assessments must be conducted no later than 365 days after the previous functional assessment, but **NOT** earlier than 45 days prior to the expiration of the 365 days.
      a) In the event any ADRC entity is unable to meet this requirement due to reasons other than delays caused, initiated, or requested by the member, the ADRC shall send an exception to policy request to KDADS PD Waiver Program Manager no later than one week prior to the expiration of the 365 days.
      b) The ADRC shall not delay the re-evaluation until the exception to the policy is approved by the KDADS PD Waiver Program Manager and communicated back to the requesting ADRC.
   2. If waiver member's annual assessment does not meet the LOC eligibility threshold and is no longer found functional eligibility for the waiver, KDADS will terminate services using the established process,
      a) The member will be notified of the determination and provided a grievance and appeal process.
   3. In the event a waiver member is not found eligible at reassessment, the following processes shall be followed:
      a) The ADRC shall send an ES-3161 Form to KDHE 3161 designated mailbox to initiate closure of HCBS services; and must copy KDADS PD Program Manager in the notification.

b) The ES-3161 Form must indicate that the waiver member is found ineligible at the annual LOC evaluation.
c) KDHE will notify KDADS, Community Mental Health Centers (CMHCs), and MCOs through a completed ES-3161 Form.
d) KDHE will send a NOW to the waiver member for a waiver eligibility discontinuance based on failure to meet functional eligibility criteria.

4. The PD Program Manager may review waiver program members' annual assessments and eligibility documents (all or randomly) for continued eligibility.

B. Individuals shall not receive an annual assessment/re-evaluation while on the waiting list.
1. Exception: If an individual on the waiting list applies for waiver services based on a crisis exception but does not have a valid assessment, the individual is eligible for a re-evaluation.

IX. Working Healthy (WH) Program, Work Opportunities Reward Kansans (WORK)

A. PD members in the WORK program can return to the PD waiver and bypass the waitlist pursuant to the HCBS WH/WORK Transition Policy posted on the KDADS website.

X. Waiting List Management

A. If there is no waiting list,
1. Entry into the waiver shall be based on a first-come, first-served basis for members determined eligible.

B. If there is a waiting list,
1. The entry position of the waiting list is based on the date and time the functional assessment is completed.

C. KDADS is responsible for managing the waiting list.
D. An applicant may bypass the waiting list process if they fall into one of the following groups:
1. A child under the custody of the Kansas DCF custody,
2. A transfer from another HCBS Technology Assisted (TA) and/or BI waiver
3. The transition from a NF through the HCBS Institutional Transition Policy
4. PD waiver program crisis exception,
5. HCBS Military Inclusion exception, and
6. Transfer from the WH, WORK program.
a) Applicants transferring from the WORK program must be reassessed for the waiver program functional eligibility within 90 days of leaving the WORK program.

E. Individuals on the waiting list do not receive annual assessments.
1. If an individual is offered a place on the waiver and does not have a current assessment (completed within 365 days of the offer), the PD Program Manager shall notify the ADRC requesting a functional assessment.

F. Waiting List Offer Round
1. If there is an offer round, the PD Program Manager shall send an offer letter to qualified individuals on the waiting list and wait for an acceptance of the offer through a completed offer letter returned from the individual offered.

a) The individual receiving the waiver program offer is required to complete a portion of the offer letter acknowledging receipt and acceptance of the program offer and must respond to their decision in one of the ways called out within the Offer Letter.

2. Upon receiving the completed offer letter from the individual,
    a) the PD Program Manager shall complete Section 3 of the E-3160 Form and email it to the ADRC, KanCare Clearinghouse, and the individual's MCO (when applicable).

G. Once the E-3160 Form has been sent to the KanCare Clearinghouse, the Program Manager shall move the individual to "Pending" on the waiting list, indicating their waiver access is pending Medicaid Financial Eligibility.

H. Upon receiving the coded E-3160 from the clearinghouse, the PD Program Manager shall upload the coded E-3160 Form into KAMIS and remove the individual from the waiting list.

I. In the event the ADRC is notified that an individual on the waiting list meets crisis criteria or requests a crisis exception, the ADRC shall follow the established process as described in the PD Crisis Policy on the KDADS website.

XI. PD Waiver Program Acceptance

A. Upon offer and acceptance into the waiver program after an applicant has met functional, program, and financial eligibility:
    1. MCO, or their designee, shall conduct a comprehensive needs assessment and develop the Person-Centered Service Plan (including both waiver and state plan services) according to the KDADS HCBS PCSP Policy.
    2. The MCO shall offer the member provider choice, offer the member the choice between self or agency direction.

XII. Designated System of Record

A. The system of record designated by the state is KAMIS.
    1. When entering an applicant's information into KAMIS the system of record, the ADRC assessor must follow the instructions below:
        a) Prior to creating a new consumer in KAMIS, a search must be completed to ensure that the applicant's information is not already in KAMIS. The search may be completed using the applicant's SSN and/or Medicaid ID.
        b) If the applicant is already in KAMIS, the ADRC assessor shall not create a new profile for the applicant but use the existing one in the system.
        c) The applicant's FIRST and LAST name must be correctly spelled and crosschecked with the E-3160 Form to ensure proper verification that the applicant is not already in KAMIS.
        d) When entering the applicant's data into KAMIS, ensure that only the most up-to-date information is entered.