Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS

Financial Management Services

Updated 02.2026

PART II
HCBS FMS FEE-FOR-SERVICE PROVIDER MANUAL

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

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

INTRODUCTION TO THE HCBS FMS PROGRAM

Updated 03/19

The Home and Community Based Services (HCBS) waiver programs are designed to meet the needs of members who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition of those members with the desire to live outside of an institution.

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

Enrollment

All HCBS FE providers must enroll and receive a provider number for HCBS services. Contact the fiscal agent to enroll. Provider enrollment information is on the Provider page of the Kansas Medical Assistance Program (KMAP) website.

Manuals

The provider manual is divided into two parts. This provider-specific section of the manual (Part II) is designed to provide information and instructions specific to providers of HCBS Financial Management Services (FMS) waiver program services. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The **Billing Instructions** subsection provides instructions on claim submission.

The **Benefits and Limitations** subsection outlines services included for HCBS FMS members and limitations on these services. It also includes qualifications for HCBS FMS providers, documentation requirements for reimbursement, and expected service outcomes.

Miscellaneous Documentation

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

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

INTRODUCTION TO THE HCBS FMS PROGRAM

Updated 02/16

HIPAA Compliance

As a member in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required during its review and investigation. The provider is required to provide access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

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

KMAP Audit Protocols

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

7000. HCBS FMS BILLING INSTRUCTIONS Updated 02/26

All claims for FMS must be submitted through the EV&M system, AuthentiCare Kansas, web application.

Introduction to the CMS 1500 Claim Form

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

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

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

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

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

Submission of Claim

Send completed claim and any necessary attachments to:

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

7010. HCBS FMS SPECIFIC BILLING INFORMATION Updated 10/16

Enter diagnosis code R68.89 in Field 21 on the CMS 1500.

Enter the authorized procedure code with the modifier (T2040 U2) in Field 24D of the CMS 1500.

One unit equals one month.

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

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 line items: the first line ends on the 15th of the month and the second line begins on the 16th with an increase of units.
>
> A claim with a line item for services dated the 8th through the 16th will deny because it conflicts with the dates that have been approved on the electronic POC. At this time, the claims system is unable to read two different lines on the POC for one line on a claim.
>
> For the first detail line item listed above (up to the 15th of the month), any service dates that fall between the 1st and the 15th of that month will be accepted by the system and not deny because of a conflict in the dates of service.

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

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

- HCBS services provided the date of admission, if provided PRIOR to member being admitted
- HCBS services provided the date of discharge, if provided FOLLOWING the member's discharge
- HCBS case management provided 30 days prior to discharge
- Emergency Response Services

7030. HCBS FMS 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 Managed Care Organization (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:
    - Level of Care (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 FMS 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.
   2. Findings from file reviews will be recorded in QRT.

Quality Assurance Procedures continued:

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

Quality Assurance Procedures continued

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

Documentation:

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

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

Documentation continued

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

7040. HCBS FMS ELECTRONIC VISIT VERIFICATION Updated 01/25

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

Claims Process

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

Provider Responsibilities

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

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

Claims Adjustments

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

8400. BENEFITS AND LIMITATIONS Updated 02/17

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Within the self-directed model and Kansas state law (K.S.A. 39-7,100), members have the right to "make decisions about, direct the provisions of and control the personal care services received by such individuals including, but not limited to selecting, training, managing, paying, and dismissing of a direct support worker."

The member or member's representative has decision-making authority over certain services and takes direct responsibility to manage these services with the assistance of a Financial Management Services provider. Kansas FMS support is available to members under the employer authority using the Centers for Medicare & Medicaid Services (CMS)-approved Vendor Fiscal Employer Agent (F/EA) model.

FMS support is available for the member or designee (a designated person assigned by the member, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to member-direct some or all services, to assist the member by performing administrative and payroll functions. FMS support will be provided within the scope of the employer authority model of FMS. FMS is available to members who reside in their own residence or in the home of a family member and have chosen to member-direct their services.

In the F/EA model, the member retains the responsibility as the common law employer. FMS supports will be provided through a third-party entity that has an established provider agreement with the Secretary of KDADS and is contracted with a KanCare MCO. The FMS provider supports the member in accordance with terms as specified in the signed agreement and this manual.

Services in support of member-direction are offered whenever a waiver affords members the opportunity to direct some or all their waiver services. Two core service definitions are provided:
(1) information and assistance in support of member direction and (2) financial management services.

FMS providers assist the member or member's representative by providing two distinct types of tasks: (1) administrative tasks and (2) information and assistance (I&A) tasks.

When a member or member's representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:

- Choose and direct support services
- Choose and direct the workers who provide the services
- Perform the roles and responsibilities as employer
- Understand the roles and responsibilities of the FMS provider
- Receive initial and ongoing skills training as requested

8400. BENEFITS AND LIMITATIONS Updated 10/16

FINANCIAL MANAGEMENT SERVICES continued

The member is the sole employer of the Direct Support Worker (DSW). The FMS provider is responsible for the provision of I&A tasks to assist the member with understanding his or her role and requirements as the employer and his or her responsibilities under member-direction. These include, but are not limited to:

1. Employer-related responsibilities, such as:
    a. Hire the DSWs who provide the member's services according to the member's integrated service plan or plan of care
    b. Determine tasks to be performed by the DSWs and where and when they are to be performed in accordance with the approved and authorized Integrated Service Plan/Plan of Care (ISP/POC)
    c. Manage and supervise the day-to-day HCBS activities of the DSWs
    d. Ensure the DSWs have resources and training on the use of the AuthentiCare Kansas (Interactive Voice Response) IVR system
    e. Verify the time worked by the DSWs was delivered according to the ISP/POC and approve and validate time worked verbally, in writing, and/or electronically
    f. Maintain the control and oversight of his or her DSWs to prevent fraud, waste, or abuse and ensure compliance with federal and state rules and regulations
    g. Ensure the DSWs are aware of their employment requirements and job responsibilities upon signing the Employment Service Agreement
    h. Ensure the DSWs are aware of the employer's requirements and job responsibilities between their member-employers and the FMS provider:
        i. Develop an emergency worker back-up plan in case a substitute DSW is ever needed on short notice or as a back-up (short-term replacement DSW)
        ii. Ensure all appropriate service documentation is recorded as required by the State of Kansas HCBS waiver program policies, procedures, or Medicaid Provider Agreement
        iii. Inform the FMS provider of any changes in the status of the DSWs, such as address or telephone number, in a timely fashion
        iv. Participate in required quality assurance visits with MCOs, State Quality Assurance Staff, or other federal and state authorized reviewers/auditors, such as Community Developmental Disability Organization (CDDO) quality assurance reviewers
    i. Promptly inform the FMS provider of the dismissal date of a DSW to avoid potential duplication or billing errors
    j. Promptly inform the FMS provider of any changes in the status of the member or member's representative, such as the member's address, telephone number, or hospitalizations.
    k. Understand and comply with federal and state policies and procedures
2. Understand the roles and responsibilities of the FMS provider, such as:
    a. Provide payroll and administrative assistance to the employer by ensuring all state and federal taxes are properly withheld and paid in accordance with state and federal requirements, including:
        i. Policies related to the FMS agreement with the employer
        ii. Process for the member to report work-related injuries incurred by the

FINANCIAL MANAGEMENT SERVICES continued

DSWs to the FMS provider to process worker's compensation claims on behalf of the member

iii. Process for notifying the FMS provider of any changes in circumstances including dates of dismissal for a DSW and work-related injuries for worker's compensation claims

b. Provide information, assistance, and referrals to employers as requested to enable members or representatives to independently direct and manage HCBS and employees including:
   i. Provide information about all aspects of member direction and subjects pertinent to the member or member's representative in managing and directing services
   ii. Explain how to set up training on the use of the IVR system as the required tool for reporting of DSWs' time and attendance
c. Submit documentation required for completing background checks and notifying the employer of the results, including whether the potential employee meets the program qualifications or has any prohibited offenses
d. Process verified time worked for employee and pay the DSWs according to the rate established by the member-employer
e. Collect appropriate client obligation from the member based on the amount determined by the State
f. Notify the appropriate entities if there is suspicion of abuse, neglect, and exploitation or Medicaid fraud, waste, and abuse

3. Understand the roles and responsibilities of the MCO care coordinator, such as:
   a. Assist the member to identify immediate and long-term needs and to develop options to meet those needs including accessing identified supports and services
   b. Assist the member to develop a backup plan in the event the DSW does not report to work
4. Understand the involuntary termination of self-direction:
   Note: The MCO may terminate the option for self-direction and offer agency-directed services according to the approved KDADS policy when one or more of the following occurs:
   a. The member or representative fails to fulfill the responsibilities and functions required, including ensuring:
      i. The client obligation is paid to the provider, if applicable.
      ii. The DSW adequately performs the services as outlined in the ISP/POC.
      iii. The member manages and monitors the DSW in accordance with HCBS program policy and state and federal rules and regulations.
      iv. The member has not abused or misused the self-directed option.
   b. Obtained evidence the member is or may be at risk of imminent harm to the member's health, safety, or welfare, and is unable or unwilling to remedy the risk:
      i. As documented by the MCO on one or more occasions

FINANCIAL MANAGEMENT SERVICES continued

ii. As confirmed by the Kansas Department for Children and Families (DCF) Adult Protective Services (APS)

c. Obtained evidence the member or representative has abused or misused the self-directed care option such as, but not limited to, the member or representative has:
   i. Repeatedly failed to pay the client obligation as required
   ii. Directed the DSW to provide, and the DSW has provided, paid services beyond the scope of the POC or scope of service definition, such as paid attendant care or sleep cycle support
   iii. Directed or allowed the DSW to provide HCBS paid services beyond the scope of the POC authorized services, such as performing tasks to support the home and pets when the member is out of town on in an institutional setting
   iv. Directed the DSW to not provide paid service supports and required the DSW to pay the member a portion of the DSW's pay
   v. Committed fraudulent acts or obtained Medicaid eligibility through fraud
   vi. Submitted and/or approved signed time sheets or Electronic Visit Verifications (EVVs) for services beyond the scope of the ISP/POC or for time and services that were not provided
   vii. Directed or allowed the DSW to provide care and services while in an institutional setting such as a hospital or nursing home
   viii. Directed or allowed the DSW to provide care and services beyond the limitations of their training or the training of the DSW for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the member

The FMS provider has the responsibility to:

1. The FMS provider ensures members directing their services and supports receive administrative assistance related to payroll, taxes, unemployment, worker's compensation, and related tasks. The FMS provider maintains a member-employer file, including related tax documentation and DSW documentation needed to perform FMS duties.
2. FMS provides employer-related information and assistance to the member as part of their FMS functions. This service does not duplicate other waiver services including case management. Where the possibility of duplicate provision of services exists, the member plan of care shall clearly delineate responsibilities for the performance of activities.
3. FMS understands individuals choosing to member-direct their services may choose any qualified FMS provider who has a current KDADS agreement and is contracted with their selected KanCare MCO.
4. The FMS provider must also maintain comprehensive policies and procedures (detailed within this manual), including but not limited to the following:
   a. Policies and procedures for billing Medicaid, in accordance with approved rates, for services authorized on the ISP/POC
   b. Policies and procedures for billing FMS administrative fees
   c. Policies and procedures to receive and disburse Medicaid funds, track disbursements, and provide reports including, but not limited to:
      i. Reports to members for billing/disbursements on their behalf
      ii. Reports to the State of Kansas, as requested

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FINANCIAL MANAGEMENT SERVICES continued

5. The FMS provider must follow all policies and procedures to ensure proper/appropriate background checks are conducted on all individuals (FMS providers and DSWs) in accordance with program requirements.
6. The FMS provider must follow all policies and procedures to ensure the members follow the pay rate reimbursement limits when setting DSWs' pay rates including:
    a. Clear identification of how this will occur
    b. Prohibition of wage/benefit setting by FMS provider
    c. Prohibition of "recruitment" of self-direct individuals (HCBS waiver member and/or DSW staff) by enticements or promises of better wages and/or benefits through improper use of Medicaid funds
7. The FMS provider must follow all policies and procedures to ensure proper/appropriate processing of time worked, disbursing of pay checks, filing of taxes, and other associated responsibilities.
8. The FMS provider must follow all policies and procedures regarding the provision of I&A services.
9. The FMS provider must follow all policies and procedures regarding a backup plan and efforts to develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency.
10. The FMS provider must follow all policies and procedures to ensure correct disbursement of pay to DSWs, including identifying, reporting, and mitigating potential fraud, waste, and abuse.
11. The FMS provider must follow all policies and procedures for reporting cases of abuse, neglect, and exploitation and Medicaid fraud, waste, and abuse to the State or other required entities.
12. The FMS provider must follow all policies and procedures regarding the dispute resolution process about employer-related grievances.

KanCare MCO provider has the responsibility to:

1. The MCO ensures persons seeking or receiving member-directed services have been informed of the benefits and responsibilities of the member direction.
2. The MCO is also responsible to do the following but not limited to:
    a. Obtain member's written appointment of designated representative (legal or nonlegal), initially and annually
    b. Assist the member in developing an emergency backup plan
    c. Inform the member's responsibility for payment of applicable client obligations
    d. Inform the member of the process for changing or discontinuing an FMS provider
    e. Inform the member of the process for voluntarily terminating an FMS provider
    f. Inform the member of the process for involuntary termination of member direction in accordance with state and federal policy, including applicable appeal rights
    g. Inform the member that the agency-directed service option can be made at any time if the member no longer desires to member-direct his or her service(s)
    h. Inform the member that DSWs are required to use the AuthentiCare Kansas IVR system to report time and attendance, task performed, and submission of claims for time worked
    i. Provide a list of FMS agents within their network to choose from
    j. Coordinate the care, services, and support for the member

FINANCIAL MANAGEMENT SERVICES continued

3. The MCO must ensure timely authorization including entering authorizations into the AuthentiCare Kansas system prior to the beginning of the first of a month for a smooth transition to ensure continuity of services.
4. The MCO is responsible for informing the member that he or she must exercise responsibility for making the choice to member-direct his or her personal care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices made.
    a. The MCO shall conduct a readiness review for each new FMS provider wishing to provide services in Kansas.
    b. The MCO shall use the state-approved tool to conduct the readiness review.
    c. The MCO shall send the results of the review along with the required documentation to the KDADS Program Integrity Manager for final approval prior to executing a contract with a new FMS provider.
5. In addition to offering the choice of FMS providers, the MCO is responsible to do the following:
    a. Provide the member with information on how to reach the MCO care coordinator
    b. Inform the FMS provider when prior authorization has been approved or modified
    c. Inform the member of the requirement to pay client obligation to the provider assigned the client obligation on the ISP/POC
    d. Inform the FMS provider when the member is hospitalized, is no longer authorized, or the member has elected to discontinue receiving member-directed services.

Enrollment Requirements

Individual organizations interested in providing FMS are required to submit the following documentation, including a signed FMS Readiness Review Tool, to KDADS prior to contracting with the MCO(s) to provide FMS services.

1. **FMS Readiness Review Tool**
    a. The FMS Readiness Review Tool must be executed annually and is required before providing FMS or continuing to provide FMS. Additionally, all FMS providers are required to execute the KDADS Business Associates Agreement (BAA).
    b. The FMS Readiness Review Tool, KDADS BAA, and enrollment requirements are available on the KDADS website.
    c. A new FMS provider is subject to a readiness review and must submit financial documentation prior to receiving and approved by the Commission of Kansas Department for Aging and Disability (KDADS).
2. **Medicaid Provider Agreement**
    a. The Medicaid Provider Agreement can only be obtained upon the presentation of a valid, approved KDADS/FMS Readiness Review Tool.
    b. A valid KMAP provider number must be obtained for billing purposes.
    c. The Medicaid provider enrollment requirements are available on the KMAP website.
3. **Registration with the Office of the Secretary of State (Kansas SOS website), if required:**
    a. The entity must be in good standing with all Kansas laws and business requirements.
    b. The owners/principles/administrators/operators must have no convictions of embezzlement, felony theft, or fraud and must not have any conviction identified on the list of prohibitive offenses.

FINANCIAL MANAGEMENT SERVICES continued

c. The owner, primary operator, and administrator of the FMS business must live in a separate household from the member receiving services from the FMS business.
d. The business is established to provide FMS to more than one member.

4. Required tax documentation

a. To qualify to provide FMS, the service provider must be a Vendor Fiscal/Employer Agent (F/EA) FMS provider operating under §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70, respectively.
b. To qualify to provide FMS, the service provider must have or obtain a separate federal employer identification number (FEIN) used only for filing federal tax forms and making federal tax payments for the member employers it represents.
c. If the FMS does not already have a FEIN, the FMS should complete and submit IRS Form SS-4: *Application for Employer Identification Number.*

5. CDDO Affiliate Agreement

a. One executed Affiliate Agreement is required if serving HCBS Intellectual/ Developmentally Disabled (I/DD) program members.
b. One executed Affiliate Agreement is required for every CDDO catchment area in which the FMS provider will operate and serve HCBS I/DD program members.

6. Insurance, defined as:

a. Minimum liability insurance (liability with a $500,000 minimum or as required)
b. Workers compensation insurance as required by the State of Kansas (see the Kansas Department of Labor website)
Note: Insurance requirements include demonstrating the associated premiums are paid in a manner that ensures continuous coverage.
c. Unemployment insurance
d. Other insurances (if applicable)

7. Financial solvency

a. An FMS provider must be able to demonstrate initial and continuing financial solvency with evidence that 30 days coverage of operational costs are met.
Note: Cash requirements will be estimated using the past quarter's performance from the date of review, or, if a new entity, the provider must estimate the number of members that they reasonably expect to serve using nominal costs.
b. Each entity, or company applying as an FMS provider must supply financial documentation for review. This documentation must include:
    i. The three most current bank statements
    ii. An open letter of credit (statement[s] from a banking or lending institution, if applicable)
    iii. A current balance sheet
    iv. A schedule of anticipated monthly expenditures
c. Each individual entity, or company providing FMS must supply financial documentation for review as detailed in Section VIII Quality Assurance and Program Integrity. This documentation must include:
    i. Independent GAAP audit by a certified public accountant
    ii. Program and financial compliance audit

FINANCIAL MANAGEMENT SERVICES continued

8. Policies and procedures
An FMS provider must prepare and maintain a comprehensive *FMS Policies and Procedures Manual* that contains written policies, procedures, and internal controls for all required FMS tasks, including those performed by a reporting agent or subagent, as applicable, and related communication, and oversight tasks.

Reimbursement
- One unit equals one month.
- Procedure code: T2040 U2

Documentation Requirements
1. **Written documentation required**
    a. Written documentation is required for services billed to the MCO or through KMAP.
    b. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.
    c. Documentation needs to be a report, database, spreadsheet, or invoice that must (at a minimum) include the following:
        i. Identification of the waiver service being provided
        ii. Member's printed name (first and last)
        iii. Member's Medicaid identification number
        iv. Date of service (MM/YY)
        v. Notes of any I&A tasks provided during contacts within the month
    d. The member's printed name and signature must be on the completed Service Agreement prior to the start of service delivery.
2. **Electronic documentation**
    a. For services required to use the IVR system in AuthentiCare Kansas, time and attendance must be recorded using the IVR system. Any claims created, corrected or otherwise adjusted in the AuthentiCare Kansas must have appropriate documentation attached.
    b. Electronic documentation, at a minimum, must include the following:
        i. Identification of the waiver service being provided
        ii. Name of the member receiving the service(s)
        iii. Date of service (MM/YY)
        iv. Notes of any I&A tasks provided during contacts within the month
        v. Member's signature authorizing the use of the electronic documentation system at the start of service delivery
    c. Electronic documentation of service delivery is allowed when meeting both documentation and signature standards as outlined above.

Benefits and limitations
1. HCBS program services, including benefits and limitations, are outlined for HCBS program members in the specific HCBS program manuals, KMAP manuals, and HCBS manuals.
2. The member or designated representative cannot receive payment for the administrative functions he or she may perform.
3. Only one FMS provider is to be authorized on a ISP/POC per month.

FINANCIAL MANAGEMENT SERVICES continued

4. Access to this service is limited to members or their representatives who direct some or all their services.

Recoupment and postpayment review

1. Postpayment review may be completed by the MCO or State to ensure compliance with requirements from CMS at any time.
    a. CMS requires each state allowing submission of electronic claims to perform random sample reviews to ensure program compliance and integrity.
    b. This process entails randomly selecting claims that have been submitted electronically. If randomly selected, the provider will receive a letter requiring acceptable documentation to be returned showing the claim was properly submitted.
2. For postpayment review, reimbursement will be recouped if documentation is not complete.
    a. Acceptable documentation requirements are identified in this manual, the appropriate KMAP ***General Billing Fee-for-Service Provider Manual***, and MCO provider manuals.
    b. The documentation, along with a copy of the original letter, must be submitted within the time frame identified in the letter.
    c. Failure to follow the postpayment review instructions or to submit the required documentation within the required time frame or submission of unacceptable documentation may result in the claims being recouped.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS FMS SERVCES

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

I. General Requirements

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

Updated 02/25

II. Adverse Incident Definitions

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

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

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

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

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

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

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

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

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

J. **Natural Disaster:** A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life. Approved emergency management protocols are to be followed, documented, and reported as required by the policy in the AIR system. A separate AIR report shall be made for all HCBS members in the area who are impacted by the natural disaster.
K. **Neglect:** The failure or omission by a caretaker, or another person with a duty to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
L. **Physical Restraint**: Any manual method of physical object or device attached or adjacent to a member's body that restricts the member's freedom of movement.
M. **Seclusion:** The involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving.
N. **Self-Neglect:** The failure or omission by oneself to supply or to provide goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
O. **Serious Injury:** An unexpected occurrence involving the significant impairment of the physical condition of a member. Serious injury specifically includes loss of limb or function.
P. **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
Q. **Suicide Attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

III. Adverse Incident Reporting Requirements

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

b) Any unauthorized use of Seclusion, Physical Restraint, or Chemical Restraint, or other restrictive intervention method, was appropriately reported.

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

C. Reporting Death
1. Death reports shall be assigned as a Level 2 incident to the MCO in the AIR system.
2. Death reports require KDADS confirmation before final resolution. KDADS shall verify the following:
    a) The deceased's expectancy of death was accurately reported.
    b) The deceased's hospice status was accurately reported.
    c) Any preventable cause was accurately identified; and
    d) The MCO observed appropriate follow-up measures.

3. The MCO investigation shall verify:
    a) If the death was expected or unexpected.
    b) If there was a preventable cause of death; and
    c) If the deceased was a recipient of hospice, then the MCO shall verify supporting documents in the form of a physician's order or hospice admission documentation.

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

Military Inclusion

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

I. Policy

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

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

iv. Proof eligible military personnel hold a current valid Kansas driver's license or non-driver identification card

4. A dependent of military personnel residing in the state of Kansas may qualify for military inclusion exception.
    a) A qualifying dependent must meet the criteria for dependency as defined by the Internal Revenue Service (IRS).
    b) Evidence supporting dependency may include, but is not limited to, the following:
        i. Recent tax return
        ii. Marriage license
        iii. Birth certificate
        iv. Court order
        v. Adoption documentation
5. The eligible military personnel or their eligible dependent must meet the functional eligibility, program eligibility, and financial eligibility requirements for the HCBS waiver program that they have requested.
    a) Financial eligibility for all HCBS waiver programs is determined by the Kansas Department for Health and Environment (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.

IV. Definitions

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

B. **Financial Eligibility** – The process whereby a member is determined to be eligible for health care coverage for reimbursement through Medicaid as determined by an authorized agent or personnel designated by the State. In this case, the Single State Medicaid Agency is the KDHE.
C. **Functional Assessment** – The current KDADS approved tool used by a state-contracted assessor to assess a person's functional eligibility.
D. **Functional Eligibility** - The process whereby a member is determined to meet the level of care need for an institutional setting to access a Medicaid-funded HCBS waiver program as determined by a state-contracted assessor.
E. **Military Personnel** – Active or reserve duty members of the armed forces including the United States Army, Navy, Marines, Air Force and Coast Guard, as well as, the activated Kansas National Guard.
F. **Program Eligibility** – The process whereby a member is determined to be eligible for a Medicaid-funded KDADS HCBS waiver program as determined by KDADS or its designated State agency.
G. **Resident** – A citizen of the United States who has a fixed home in Kansas, does not intend to leave Kansas and whenever absent, if for temporary purposes, intends to return to Kansas as evidenced by several factors found in K.A.R. 92-12-4a, including, but not limited to, spending more than six months of the taxable year in Kansas, voting or being registered to vote in Kansas, obtaining or maintaining a current valid driver's license or non-driver identification card, and paying Kansas income and property taxes and that person's domicile is within Kansas.
H. **State-contracted Assessor** – Authorized agent or personnel, approved by the State, responsible for completing the functional eligibility assessments for individuals applying for KDADS HCBS waiver programs.