Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

HCBS
Frail Elderly

Updated 09.2025

PART II
HCBS FE FEE-FOR-SERVICE PROVIDER MANUAL

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FORMS All forms pertaining to this provider manual can be found on the public website and on the secure portals under Provider and Forms. Sample forms may be used to document HCBS FE services. Use of these forms is not required, but they can be duplicated for your use.

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

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INTRODUCTION TO THE HCBS FE PROGRAM

Updated 03/23

The Home and Community Based Services for the Frail Elderly (HCBS FE) waiver program is designed to meet the needs of members 65 years of age and older 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.

Services include:

- Adult Day Care
- Assistive Technology
- Personal Care Services (PCS)
- Comprehensive Support
- Financial Management Services (FMS)
  Note: Refer to the *HCBS Financial Management Services (FMS) Fee-for-Service Provider Manual* for criteria and information.
- Home Telehealth
- Medication Reminder
- Nursing Evaluation Visit
- Oral health services
  Note: Refer to the *Dental Fee-for-Service Provider Manual* for criteria and information.
- Personal Emergency Response
- Enhanced Care Services
- Wellness Monitoring

All HCBS FE 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 FE services. Contact the fiscal agent to enroll.

Documentation 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

INTRODUCTION TO THE HCBS FE PROGRAM

Updated 12/16

Signature Limitations for All FE Services

In all situations, the expectation is that the member provides oversight and accountability for people providing services for them. 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 may be anyone who is aware services were provided. The individual providing the services **cannot** sign the time sheet on behalf of the member.

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

- 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 no legitimate reason should be advised that the PCS 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.

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 public portal under the *Provider Documents* heading.

7000. HCBS FE BILLING INSTRUCTIONS Updated 10/17

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 portals, 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 Claims Form and instructions are available on the KMAP public and secure portals under the Claims (Sample Forms and Instructions) heading of the Forms section 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 Claim

Send completed claim and any necessary attachments to:

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

All claims for HCBS FE services, except oral health services, 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 FE SPECIFIC BILLING INFORMATION Updated 07/24

ADULT DAY CARE
Enter diagnosis code R6889 in Field 21 of the CMS 1500.

Adult Day Care, half day
Enter procedure code S5101 in Field 24D of the CMS 1500.
One unit equals one to five hours and is limited to one unit per day.

Adult Day Care, per diem
Enter procedure code S5102 in Field 24D of the CMS 1500.
One unit equals more than five hours and is limited to one unit per day.

Only one Adult Day Care service (either S5101 or S5102) can be billed on the same day by the same provider.

ASSISTIVE TECHNOLOGY
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
Enter procedure code T2029 in Field 24D of the CMS 1500.
One unit equals one purchase.

COMPREHENSIVE SUPPORT
Enter diagnosis code R6889 in Field 21 of the CMS 1500.

Provider-Directed Comprehensive Support
Enter procedure code S5135 in Field 24D of the CMS 1500.
One unit equals 15 minutes.

Self-Directed Comprehensive Support
Enter procedure code with modifier, S5135UD, in Field 24D of the CMS 1500.
One unit equals 15 minutes.

ENHANCED CARE SERVICES
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
Enter procedure code T2025 in Field 24D of the CMS 1500.
One unit equals a minimum of six hours. Only one unit is allowed within a 24-hour period of time.

HOME TELEHEALTH
Enter procedure code S0317 in Field 24D of the CMS 1500.
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
One unit equals one day.
Installation of Home Telehealth equipment and training – Enter procedure code S0315 in Field 24D of the CMS 1500. Effective with dates of service on and after August 1, 2024, modifier U1 must be appended with procedure code S0315.
Installation is covered up to twice per calendar year.

7010. HCBS FE SPECIFIC BILLING INFORMATION Updated 05/25

MEDICATION REMINDER
Enter procedure code S5185 in Field 24D of the CMS 1500.
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
One unit equals one month.

NURSING EVALUATION VISIT
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
Enter procedure code T1001 in Field 24D of the CMS 1500.
One unit equals one face-to-face visit.

PERSONAL CARE SERVICES (PCS)
Enter diagnosis code R6889 in Field 21 of the CMS 1500.

Provider-Directed PCS
Level One - Enter procedure code S5130 in Field 24D of the CMS 1500.
Level Two - Enter procedure code S5125 in Field 24D of the CMS 1500.
Level Three - Enter procedure code with modifier S5125UA in Field 24D of the CMS 1500.
One unit equals 15 minutes.

Self-Directed PCS
Enter procedure code with the modifier, S5125UD, in Field 24D of the CMS 1500.
One unit equals 15 minutes.

PERSONAL EMERGENCY RESPONSE
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
Rental of Personal Emergency Response - Enter procedure code S5161 in Field 24D of the CMS 1500.
One unit equals one month.
Installation of Personal Emergency Response - Enter procedure code S5160 in Field 24D of the CMS 1500.
Installation is covered up to twice per calendar year.

WELLNESS MONITORING
Enter diagnosis code R6889 in Field 21 of the CMS 1500.
Enter procedure code S5190 in Field 24D of the CMS 1500 when Wellness Monitoring service is provided in an individual setting.
Enter procedure code S5190 with modifier UA in Field 24D of the CMS 1500 when Wellness Monitoring service is provided in a congregate setting.
One unit equals one face-to-face visit.

Note: Although for billing purposes the system POC is authorized monthly, the total hours for a member cannot exceed the daily or weekly approved amount as specified in the Customer Service Worksheet, if applicable, written POC, and the Notice of Action (NOA).

7010. HCBS FE SPECIFIC BILLING INFORMATION Updated 10/17

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
- Emergency Response Services

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

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

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

Compliance Requirements for Providers:

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

S5101	S5102	S5125	T2016	T2021

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

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

Providers will be required to obtain annual certification from the Kansas Department of 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 Kansas Department of Health and Environment (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 FE 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 FE 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 FE 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.

7030. HCBS FE QUALITY ASSURANCE Updated 09/24

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. Backup 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 FE ELECTRONIC VISIT VERIFICATION Updated 01/25

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

Claims Process

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

Provider Responsibilities

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

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

7040. HCBS FE ELECTRONIC VISIT VERIFICATION Updated 09/25

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

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

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

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

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

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

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

Waiver	Service	Code	EVV Code
Frail Elderly	Nursing Evaluation Visit	T1001	HCFET1001

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 07/24

ADULT DAY CARE

This service is designed to maintain optimal physical and social functioning for HCBS members. This service provides a balance of activities to meet the interrelated needs and interests (for example, social, intellectual, cultural, economic, emotional, and physical) of HCBS members.

This service includes:

- Basic nursing care as delegated or provided by a licensed nurse and as identified in the service plan.
- Daily supervision/physical assistance with certain activities of daily living limited to eating, mobility, and may include transfer, bathing, and dressing as identified in the Customer Service Worksheet (CSW).

This service shall not duplicate other waiver services.

ADULT DAY CARE LIMITATIONS

- Service may not be provided in the member's own residence.
- Members living in an assisted living facility, residential health care facility, or home plus facility are not eligible for this service.
- Service is limited to a maximum of two units of service per day, one or more days per week.
- A registered nurse (RN) must be available on-call as needed.
- Special dietary needs are not required but may be provided as negotiated on an individual basis between the member and the provider. No more than two meals per day may be provided.
- Transfer, bathing, toileting, and dressing are not required but may be provided as negotiated on an individual basis between the member and the provider as identified in the individual's POC and if the provider is capable of this scope of service.
- Therapies (physical, occupational, and speech) and transportation are not covered under this service but may be covered through regular Medicaid.

ADULT DAY CARE ENROLLMENT

Providers must be licensed by KDADS. Licensed entities include free-standing adult day care facilities, nursing facilities, assisted living facilities, residential health care facilities, and home plus facilities.

ADULT DAY CARE REIMBURSEMENT

Adult Day Care, half day
One unit equals one to five hours and is limited to one unit per day.
Procedure code is S5101.

Adult Day Care, per diem
One unit equals more than five hours and is limited to one unit per day.
Procedure code is S5102.

ADULT DAY CARE continued
The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery, provide consistency with other Medicaid services such as home health aide visits, and meet member preferences in providers and service delivery methods. The member will be monitored through case management. This will ensure providers deliver the necessary scope of service as agreed and defined in the POC regardless of the length of time needed to deliver service.

ADULT DAY CARE DOCUMENTATION REQUIREMENTS
For a service provided within a licensed nursing, assisted living, residential health care, or home plus facility, written documentation is required for services provided and billed to KMAP. Documentation, at a minimum, must consist of an attendance record. This record must include the following:

- Identify the waiver service being provided (Adult Day Care)
- Member's initials each visit if using an attendance record covering more than one day
- Member's name (first and last) and signature, at a minimum each week
- Name and signature of authorized staff member
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

This record must be generated and maintained during the time frame covered by the document. Generating documentation after-the-fact is not acceptable. A sample of the HCBS FE Adult Day Care Log is on the KMAP public and secure portals and may be used to document HCBS FE services. Use of this specific form is not required, but it may be duplicated for your use.

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

For a service provided in a licensed free-standing adult day care facility, documentation is required for services provided and billed to KMAP and must be collected using the EV&M system, AuthentiCare Kansas. Electronic visit verification documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Adult Day Care)
- Identification of the member receiving the service (first and last name)
- Identification of the authorized staff member
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

Note: For members who have been notified by their MCO to receive services under Expedited Service Delivery (ESD), the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 07/25

ASSISTIVE TECHNOLOGY

Assistive technology (AT) consists of either one of the following:

- Purchase of an item or piece of equipment that improves or assists with functional capabilities including, but not limited to, grab bars, bath benches, toilet risers, and lift chairs
- Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings

ASSISTIVE TECHNOLOGY LIMITATIONS

- AT is limited to the member's assessed level of service need, as specified in the member's POC, subject to an exception process established by the State. All members are held to the same criteria when qualifying for an exception in accordance with the established KDADS policies and guidelines.
- All AT purchases require prior authorization from KDADS.
- This service must be cost-effective and appropriate to the member's needs.
- This service is limited to a lifetime maximum of $10,000.
- AT funded by other waiver programs is calculated into the lifetime maximum.
- Payment is for the item or modification and does not include administrative costs.
- Repairs or maintenance are not allowed for home modifications or assistive items.
- Home modification includes only those adaptations that are necessary to accommodate the mobility of the member.
- Replacements and duplicate items shall not be covered for the first twelve months after the purchase date of the item.
- For home modifications to be authorized in a home not owned by the member, the owner/landlord must agree, in writing, to maintain the modifications for the time period in which the HCBS FE member resides there.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- External modifications (such as, porches, decks, and landings) will only be allowed to the extent required to complete the approved request.
- Home accessibility adaptations cannot be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- If Medicare covers an AT item but denies authorization, HCBS FE will cover only the difference between the standardized Medicare portion of the item and the actual purchase price.

ASSISTIVE TECHNOLOGY ENROLLMENT

Any business, agency, or company that furnishes AT items or services is eligible to enroll. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, then a letter from the county or city must be provided stating licensure or certification is not required.

ASSISTIVE TECHNOLOGY REIMBURSEMENT

One unit equals one purchase.
Procedure code is T2029.

ASSISTIVE TECHNOLOGY continued

ASSISTIVE TECHNOLOGY DOCUMENTATION REQUIREMENTS

Written documentation is required for services provided and billed to KMAP. Documentation must include the following:

- The provider must maintain a copy of the receipt identifying that the service was provided. The receipt must include:
  - Name of the provider
  - Identification of item or technology being provided
  - Date of service (MM/DD/YY)
  - Amount of purchase
  - Member's name (first and last) and signature
- Documentation must be generated at the time of purchase. Generating documentation after-the-fact is not acceptable. A sample of the HCBS FE Assistive Technology Receipt is on the KMAP public and secure portals under the HCBS heading of the Forms section of Provider Publications and can be used to document HCBS FE services. Use of this specific form is not required, but it may be duplicated for your use.
- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

8400. BENEFITS AND LIMITATIONS Updated 07/25

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

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

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

Key Implementation Guidelines:

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

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

Timely Evaluation:

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

Spending Cap:

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

Provider Engagement and Oversight:

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

Quality Assurance and Training:

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

Grievance and Tribal Provisions:

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

Action Required:

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

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

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

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

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

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

Instances

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

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

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

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

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

Instructions and Limitations

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

Provider Type

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

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

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

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

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

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

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

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

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

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

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

Instructions and Limitations

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

VMS shall include:

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

The following as specifically excluded from VMS:

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

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

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

Provider Type

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

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

3. **Individual Contractor (Direct Contractor)**
   c. Enrolled in KanCare
   d. Appropriately licensed in service
   e. Certificate of Workers Compensation and General Liability Insurance
   f. Proof of business establishment for a minimum of 2 consecutive years
   g. Passing background checks consistent with the KDADS background check policy
   h. 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.

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.

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

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.

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.

UNBUNDLING ASSISTIVE SERVICES for HCBS WAIVERS continued

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

8400. BENEFITS AND LIMITATIONS Updated 12/16

PERSONAL CARE SERVICES

There are two methods of providing PCS, provider-directed and self-directed. Members are given the option to self-direct their PCS. A combination of service providers and types of PCS either provider-directed and/or self-directed, may be used to meet the approved POC.

PROVIDER-DIRECTED PCS

PCS provide supervision and/or physical assistance with instrumental activities of daily living (IADLs) and activities of daily living (ADLs) for members who are unable to perform one or more activities independently (K.S.A. 65-6201). PCS may be provided in the member's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

There are three levels of provider-directed PCS, which are referred to as Level I, Level II, and Level III. A combination of Level I (Services A & B) and Level II (Services C & D) can be used in the development of the POC. If a combination of Level I and Level II services are included in the POC, the Level II rate shall be paid if both levels of care are provided by the same provider. Level III will be used in the development of the POC for those members residing in adult care homes. For boarding care homes, the tasks authorized on the POC must fall within the licensing regulations.

A PCS worker who is a certified home health aide or a certified nurse aide must not perform any health maintenance activities without delegation by a licensed nurse. A certified home health aide or certified nurse aide must not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.

PERSONAL CARE SERVICE continued

LEVEL I	LEVEL II*	LEVEL III
Service A	**Service C**	**IADLs**
Home Management of IADLs • Shopping • House Cleaning • Meal Preparation • Laundry	ADLs Physical Assistance or Total Support • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services	• Shopping • House Cleaning • Meal Preparation • Laundry • Medication Set-up, Cueing, or Reminding, and Treatments
Service B	**Service D**	**ADLs**
IADLs • Medication Set-Up, Cueing, and Reminding (supervision only) ADLs PCS worker supervises the member • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services	Health Maintenance Activities • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral care • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance	Supervision, Physical Assistance, or Total Support • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services
**An initial RN evaluation visit is necessary for Level II services.*		**Health Maintenance Activities**
		• Monitoring vital signs • Ostomy care • Catheter care • Enteral care • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance • Supervision and/or training of nursing procedures

PERSONAL CARE SERVICES continued

ENROLLMENT FOR LEVEL I SERVICES

For Service A only

- Nonmedical resident care facilities licensed by the Kansas Department for Children and Families (DCF)
- Entities not licensed by DCF, KDADS, or KDHE must provide the following:
  - A certified copy of its Articles of Incorporation or Articles of Organization
    Note: If a corporation or limited liability company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.
  - Written proof of liability insurance or a surety bond

For Services A or B

- County health departments
- The following entities licensed by KDHE:
  - Medicare-certified home health agencies
  - State-licensed home health agencies
- The following entity licensed by KDADS:
  - Boarding care homes

REIMBURSEMENT

One unit equals fifteen minutes.
Procedure code is S5130.

ENROLLMENT FOR LEVEL II SERVICES C OR D

- County health departments
- The following entities licensed by KDHE
  - Medicare-certified home health agencies
  - State-licensed home health agencies

REIMBURSEMENT

One unit equals fifteen minutes.
Procedure code is S5125.

ENROLLMENT FOR LEVEL III SERVICES

The following entities licensed by KDADS:

- Home plus facilities
- Assisted living facilities
- Residential health care facilities

REIMBURSEMENT
One unit equals fifteen minutes.
Procedure code is S5125UA.

MEDICATION ADMINISTRATION/ASSISTANCE IN LICENSED FACILITIES
(K.A.R. 26-41-205 and K.A.R. 26-42-205)

- Any resident can self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.
- Any resident who self-administers medication can select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.
- If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.

MEDICATION ADMINISTRATION ASSISTANCE IN A PRIVATE RESIDENCE
(K.A.R. 28-51-108)

- A KDHE-licensed or Medicare-certified home health agency can provide nursing delegation to aides with sufficient training.
- The nurse delegation and training must be specific to the particular member and his or her health needs.
- The qualified nurse retains overall responsibility.

PCS DOCUMENTATION REQUIREMENTS
Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable. Written documentation must be clearly written 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:

- Identification of the waiver service being provided (PCS) Level I or II)
- Identification of the member receiving the service (first and last name)
- Identification of the personal care service worker providing the tasks

PERSONAL CARE SERVICES continued

- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours
- Identification of activities performed during each visit

For a postpayment review, reimbursement will be recouped if documentation is not complete.

In Home Care

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (PCS, Level I or II)
- Member's name (first and last) and signature on each page of documentation
- PCS worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked
  Note: Billing staff may round the total to the quarter hour at the end of a billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Note: For members who have been notified by their MCO to receive PCS Level I or II under ESD, the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

Assisted Living Facilities, Residential Health Care Facilities, Home Plus Facilities, and Boarding Care Homes:

Written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (PCS, Level III)
- Member's name (first and last) and signature must be on each page of documentation
- PCS worker's name and signature must be on each page of documentation
- Date of service (MM/DD/YY)
- Time spent daily for services rendered
- Identify activities performed during each contact
- Time totaled by actual minutes and hours worked
  Note: Billing staff may round the total to the quarter hour at the end of the billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

PERSONAL CARE SERVICES continued

Personal Care Services in Congregate Settings (Level III)
Effective with dates of service on and after December 3, 2023, the PCS provided in a licensed assisted living, residential health care, home plus, or boarding care facility will be exempt from the EVV requirement. PCS in Congregate settings are currently identified by using S5125 UA for HCBS/FE.

Limitations (Levels I, II, and III)

- PCS workers must be 18 years of age or older.
- Covered ADL and IADL services are limited as defined within the CSW and approved POC.
- PCS is limited to a maximum of 48 units (12 hours) per day of any combination of provider-directed Level I, provider-directed Level II, and self-directed. PCS is limited to a maximum of 48 units (12 hours) per day for provider-directed Level III.
- Transportation is not covered with this service, but, if medically necessary, it may be covered through regular Medicaid.
- A member's spouse, guardian, conservator, person authorized as an activated durable power of attorney (DPOA) for health care decisions, or an individual acting on behalf of a member shall not be paid to provide PCS for the member. The only exception to this policy will be a relative who is an employee of an assisted living facility, residential health care facility, or home plus facility in which the member resides, and the relative's relationship is within the second degree of the member. (See K.A.R. 26-41-101 and K.A.R. 26-42-101 for regulatory requirements.)
- The service will not be paid while the member is hospitalized, in a nursing home, or in any other situation where the member is not available to receive the service.
- More than one PCS worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and the case log by the case manager, for example, two-man lift for safety issues.
- PCS workers are not allowed to work and be paid for multiple HCBS members at the same date and time.

SELF-DIRECTED PCS
PCS provide supervision and/or physical assistance with IADLs and ADLs for members who are unable to perform one or more activities independently (K.S.A. 65-6201). PCS may be provided in the member's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

PERSONAL CARE SERVICES continued

IADLs	ADLs	Health Maintenance Activities
• Shopping • House Cleaning • Meal Preparation • Laundry • Medication Set-up, Cueing, or Reminding, and Treatments	• Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services	• Monitoring vital signs • Ostomy care • Catheter care • Enteral care • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance • Supervision and/or training of nursing procedures

Members or their representatives are given the option to self-direct their PCS. The member's representative may be an individual acting on behalf of the member, an activated DPOA for health care decisions, or a guardian and/or conservator. If the member or representative chooses to self-direct PCS, he or she is responsible for making choices about PCS including referring for hire, supervising, and terminating the employment of Personal Care Service workers; understanding the impact of those choices; and assuming responsibility for the results. Self-directed PCS is subject to the same quality assurance standards as other Personal Care Service providers including, but not limited to, completion of the tasks identified on the Customer Service Worksheet.

Refer to the *HCBS Financial Management Service (FMS) Fee-for-Service Provider Manual* for additional information on responsibilities.

According to K.S.A. 65-1124(I), a member who chooses to self-direct care is not required to have PCS supervised by a nurse. Furthermore, K.S.A. 65-6201(d) states that health maintenance activities can be provided ". . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home." Health maintenance activities and medication set up must be authorized, in writing, by a physician or licensed professional nurse.

ENROLLMENT
To enroll, providers must meet the provider requirements for FMS.
PCS workers must be referred to the enrolled FMS provider of the member's choice for completion of required human resources and payroll documentation.

DOCUMENTATION REQUIREMENTS
Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable**.** Written documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

PERSONAL CARE SERVICES continued

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 waiver service being provided (Self-Directed PCS)
- Identification of the member receiving the service (first and last name)
- Identification of the PCS worker providing the tasks
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Self-Directed PCS)
- Member's name (first and last) and signature on each page of documentation
- PCS worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours
- Identification of activities performed during each visit
- Time totaled by actual minutes and hours worked
  Note: Billing staff may round the total to the quarter hour at the end of a billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Note: For members who have been notified by their MCO to receive services under ESD, the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

REIMBURSEMENT
One unit equals 15 minutes.
Procedure code with modifier is S5125UD.

PERSONAL CARE SERVICES continued

LIMITATIONS

- PCS workers must be 18 years of age or older.
- A member who has a guardian and/or conservator cannot choose to self-direct his or her PCSs; however, a guardian and/or conservator can make that choice on the ward's behalf.
- A guardian, conservator, person authorized as an activated DPOA for health care decisions, or individual acting on behalf of the member cannot choose himself or herself as the paid PCS worker. If the designation of the appointed representative is withdrawn, the individual may become the member's paid PCS worker after the next annual review or a significant change in the member's needs occurs prompting a reassessment.

EXCEPTION to this limitation: Members who were active on any HCBS waiver prior to July 1, 2000, and have had the same representative continually directing their care during that time, are exempt from this limitation. The MCO shall complete a home visit at least every three months to ensure that the selected PCS worker is performing the necessary services.

- While a family member may be paid to provide PCS, a member's spouse will not be paid to provide PCS unless one of the following criteria from K.A.R. 30-5-307 are met and prior approval received from the KDADS TCM program manager:
  - Three HCBS provider agencies furnish written documentation that the member's residence is so remote or rural that HCBS services are otherwise completely unavailable.
  - Two health care professionals, including the attending physician, furnish written documentation that the member's health, safety, or social well-being would be jeopardized. (Documentation must contain how or in what way the member's health, well-being, safety, or social well-being would be jeopardized.)
  - The attending physician furnishes written documentation that, due to the advancement of chronic disease, the member's means of communication can be understood only by the spouse.
  - Three HCBS providers furnish written documentation that delivery of HCBS services to the member poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable.
- The MCO and the member or his or her representative will use discretion in determining if the selected PCS worker can perform the needed services.
- Covered ADL and IADL services are limited as defined within the CSW and approved POC.
- PCS is limited to a maximum of 48 units (12 hours) per day of any combination of provider-directed Level I, provider-directed Level II and self-directed.
- Transportation is not covered with this service, but, if medically necessary, it may be covered through regular Medicaid.
- This service will not be paid while the member is hospitalized, in a nursing home, or in any other situation where the member is not available to receive the service.
- More than one PCS worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and case log by the case manager, such as two-man lift for safety issues.

PERSONAL CARE SERVICES continued

- PCS workers are not allowed to work and be paid for multiple HCBS members at the same date and time.
- A member residing in an assisted living facility (ALF), residential health care facility (RHCF), home plus facility, or boarding care home has chosen that provider as his or her selected caregiver. These housing choices supersede the self-directed care choice.

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:** MCOs should use clinical judgment, in consultation with the provider and PCSP, to determine the appropriateness of PCS.

Authorization and Provider Requirements:

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

Documentation and Claims Submission Requirements:

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

Applicable Procedure Codes:

Service	KMAP Codes
Personal Care Services	S5130 (Level 1), S5125 (Level 2), S5125 UB (Self-directed)

8400. BENEFITS AND LIMITATIONS Updated 10/17

COMPREHENSIVE SUPPORT

Comprehensive Support is one-on-one, nonmedical assistance, observation, and supervision provided for a cognitively impaired adult to meet his or her health and welfare needs. The provision of comprehensive support does not entail hands-on nursing care: the primary focus is supportive supervision.

The worker is present to supervise the member and to assist with incidental care as needed, as opposed to PCS which is task specific. Leisure activities (for example, reading mail, books, and magazines or writing letters) may also be provided. Comprehensive Support may be provided in the member's choice of housing, including temporary arrangements.

This service shall not duplicate other waiver services.

There are two methods of providing Comprehensive Support, provider-directed and self-directed. Members are given the option to self-direct their comprehensive support. A combination of service providers, either provider-directed and/or self-directed, can be used to meet the approved POC.

The member's representative is given the option to self-direct the member's Comprehensive Support. He or she may be an individual acting on behalf of the member, a person authorized as an activated DPOA for health care decisions, a guardian, or a conservator. If the representative chooses to self-direct comprehensive support, he or she is responsible for making choices about Comprehensive Support, including referring for hire, supervising and terminating the employment of PCS workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

Refer to the *HCBS Financial Management Services (FMS) Fee-for-Service Provider Manual* for additional information on responsibilities.

COMPREHENSIVE SUPPORT LIMITATIONS

- Comprehensive Support is limited to the member's assessed level of service need, as specified in the member's POC, not to exceed 12 hours per 24-hour time period, subject to an exception process established by the State. All members are held to the same criteria when qualifying for an exception, in accordance with the established KDADS policies and guidelines.
- PCS workers must be 18 years of age.
- Comprehensive Support is limited to a maximum of 48 units (12 hours) a day to occur during the member's normal waking hours. Comprehensive Support in combination with other FE waiver services cannot exceed 24 hours a day.
- A member who has a guardian and/or conservator cannot choose to self-direct his or her Comprehensive Support; however, a guardian and/or conservator can make that choice on the member's behalf.
- Under no circumstances shall a member's spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a member be paid to provide Comprehensive Support for the member.
- For a member self-directing, the MCO and the member or his or her representative will use discretion in determining if the selected worker can perform the needed services.

COMPREHENSIVE SUPPORT continued

- Members residing in an assisted living facility, residential health care facility, home plus facility, or boarding care home must have this service provided by a licensed home health agency and are not eligible to self-direct this service.
- An individual providing Comprehensive Support must have a permanent residence separate and apart from the member.
- This service is limited to those members who live alone or do not have a regular caretaker for extended periods of time.
- Comprehensive Support cannot be provided at the same time as HCBS FE PCS or HCBS FE Enhanced Care Services.
- This service will not be paid while the member is hospitalized, in a nursing home, or in any other location where he or she is unable to receive the service.
- Workers are not allowed to work and be paid for multiple HCBS members at the same date and time.

PROVIDER-DIRECTED COMPREHENSIVE SUPPORT ENROLLMENT

- Medicare-certified or KDHE-licensed home health agencies
- CILs
- County health departments
- Entities not licensed by DCF, KDADS, or KDHE
  Note: These entities must provide the following documentation:
  - A certified copy of its Articles of Incorporation or Articles of Organization. If a corporation or limited liability company is organized in a jurisdiction outside the State of Kansas, the entity must provide written proof that it is authorized to do business in the State of Kansas.
  - Written proof of liability insurance or surety bond.

SELF-DIRECTED COMPREHENSIVE SUPPORT ENROLLMENT

To enroll, providers must meet the provider requirements for FMS. Workers must be referred to the enrolled FMS provider of the member's choice for completion of required human resources and payroll documentation.

COMPREHENSIVE SUPPORT REIMBURSEMENT

One unit equals 15 minutes.
Procedure code is S5135.
Procedure code with modifier is S5135UD.

COMPREHENSIVE SUPPORT DOCUMENTATION REQUIREMENTS

Documentation is required for services provided and billed to KMAP. Documentation must be generated at the time of the visit. Generating documentation after this time is not acceptable.

COMPREHENSIVE SUPPORT continued

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 waiver service being provided (Comprehensive Support)
- Identification of the member receiving the service (first and last name)
- Identification of the worker providing the tasks
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Comprehensive Support)
- Initials of both member and PCS worker for each visit if using a log which covers more than one day
- Member's name (first and last) and signature, on each page of documentation
- PCS worker's name and signature, on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours
- Time must be totaled by actual minutes and hours worked.
  Note: Billing staff may round the total to the nearest quarter hour at the end of a billing cycle.

For a postpayment review, reimbursement will be recouped if documentation is not complete.

- Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment. Sample forms are on the KMAP public and secure portals. They may be used to document HCBS FE services. Use of these specific forms is not required, but they may be duplicated for your use.

Note: For members who have been notified by their MCO to receive services under ESD, the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 12/16

HOME TELEHEALTH

Home Telehealth is a remote monitoring system that enables the member to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the member's health declines. The provision of Home Telehealth involves member education specific to one or more diseases (e.g. COPD, CHF, hypertension, and diabetes), counseling, and nursing supervision.

- Home Telehealth automates disease management activities and engages members with personalized daily interactions and education to build and expand their self-management behaviors. The service will enable telehealth providers, after determining the member's progress, to motivate behavior changes through user-friendly technology, helping members meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.
- Remote Monitoring Technology could include, but is not limited to, a cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation and/or touchscreen, vital sign telemonitoring mattress, web applications, and phone applications.
- The service benefits are to improve the member's ability to meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions and to lower healthcare costs.
- The technology is located in the member's home, in an area appropriate for the specific technology being used (e.g. a telemonitoring mattress in the bedroom, a web application on the member's own computer or device provided specifically for the monitoring).
- Telemonitoring services supplement rather than replace face-to-face physician visits and are scheduled with the member's provider. If the member requires general supervision and protective oversight or overnight staff support, provisions are made in the member's Integrated Service Plan of Care (ISPOC).
- The provider accesses the telehealth system to review each member's baseline (defined by the member's physician at enrollment and indicated in the ISPOC), trended survey responses, and vital sign measurements. A licensed nurse monitors the health status of multiple members and is alerted if vital parameters or survey responses indicate a need for follow-up by a healthcare professional.
- Telehealth services are provided on an individualized basis for members who have an identified need in their ISPOC. Member options and information are provided and discussed during the development of the ISPOC.
- Monitoring is initiated by the member. The member has full control over the equipment to maintain his or her right to privacy.
  The member must be trained on how to use the designated equipment by the provider and/or equipment supplier. Equipment examples could include items such as a cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation and/or touchscreen, vital sign telemonitoring mattress, web applications, and phone applications.
- The provider must ensure ongoing member education specific to one or more diseases, counseling, and nursing supervision. Education must include topics such as symptoms to report, disease processes, risk factors, and other relevant aspects relating to the disease(s).

HOME TELEHEALTH continued

- A member can qualify for this service if either of the following apply:
    - The member is in need of disease management consultation and education AND has had two or more hospitalizations, including emergency room (ER) visits, within the previous year related to one or more diseases.
    - The member is using MFP to move from a nursing facility back into the community.
- HCBS FE Home Telehealth services are not a duplication of Medicare/Medicaid telehealth services.
    - Even though the Kansas legislature calls this service "home telehealth", the actual service follows the Centers for Medicare & Medicaid Services (CMS) telemonitoring definition which Medicare does not cover. HCBS FE Home Telehealth is a daily monitoring of the member's vital sign measurements from the member's home setting to attempt to divert a crisis episode; whereas Medicare telehealth includes specific planned contacts for professional consultations, office visits, and office psychiatry services, usually through video contact.
    - During the MCO development of the ISPOC approval process, the MCO will confirm there is no prior authorization for Medicaid home telehealth skilled nursing visits. If a prior authorization is identified, the HCBS FE Home Telehealth services will be denied.
- A backup plan must be documented in the member's ISPOC in case of equipment malfunction. A response time must be included in the backup plan to avert any potential crisis situation.
- The services delivered through telemonitoring must comply with applicable state and federal laws related to the member's right to privacy.
- Members will be provided choice by the MCO care coordinator during the development of the member's service plan.

HOME TELEHEALTH LIMITATIONS

- A registered nurse (RN) or licensed practical nurse (LPN) with RN supervision must set up, supervise, and provide member counseling.
- The member must have a landline or wireless connection.
- Installation is required within 10 working days of approval.
- A maximum of two installations are covered per calendar year. Monthly status reports must be provided to the physician and MCO care coordinator.
- Contact with the member must be provided at least once a month to reinforce positive self-management behaviors.

Note: If a member fails to perform daily monitoring for seven consecutive days, the MCO care coordinator must be notified to determine if continuation of the service is appropriate.

Note: A member living in an assisted living facility, residential health care facility, or home plus facility is not eligible for this service.

HOME TELEHEALTH continued

HOME TELEHEALTH ENROLLMENT

Providers can include home health agencies or county health departments with system equipment capable of monitoring member vital signs daily. This includes (at a minimum) heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature. Also, the provider must have the capability to ask the member questions which are tailored to his or her diagnosis.

The provider and equipment must have needed language options such as English, Spanish, Russian, and Vietnamese.

HOME TELEHEALTH REIMBURSEMENT

Procedure code is S0317.
One unit equals one day of service.

Install/Training

Procedure code is S0315 with modifier U1.
One unit equals one installation (maximum of two installations per calendar year).

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

HOME TELEHEALTH DOCUMENTATION REQUIREMENTS

Medicaid requires written documentation of services provided and billed to KMAP. Documentation, at a minimum, must include the following:

- Identification of the waiver service being provided
- Member's name (first and last)
- Nurse's name and signature with credentials
- Date of service (MM/DD/YY)
- Clinical measurements, as needed, based on the member's presentation
- Review of systems, as needed, based on the member's presentation
- Additional observations, interventions, and teaching issues

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

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

HOME TELEHEALTH LIMITATIONS continued

Electronic Documentation
Documentation must include the following:

- Waiver service being provided (Home Telehealth)
- Member receiving the service
- Nurse providing the service(s)
- Date of service (MM/DD/YY)
- Clinical measurements, as needed, based on the member's presentation
- Review of systems, as needed, based on the member's presentation
- Additional observations, interventions, and teaching issues
- Member's signature authorizing the use of the electronic documentation system at the start of service delivery

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

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

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

Place of Service Codes:

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

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

Authorized Services and Applicable Codes:

Service	KMAP Codes
Home Telehealth	S0317 (with R6889 diagnosis code)
Personal Care Services – Agency	*Level 1:* S5130 *Level 2:* S5125 *Level 3:* S5125 UA

IMPLEMENTATION OF VIRTUAL DELIVERY OF SERVICES continued

Key Policy Considerations:

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

MEDICATION REMINDER

A medication reminder service provides a scheduled reminder to a member when it's time for him or her to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the provider's system.

This service does not duplicate other waiver services.

MEDICATION REMINDER LIMITATIONS

- Maintenance of rental equipment is the provider's responsibility.
- Repair/replacement of rental equipment is not covered.
- Rental, but not purchase, of equipment is covered.
- This service is limited to a member who lives alone (or who is alone a significant portion of the day) in a residential setting, does not have a regular caretaker for extended periods of time, and would otherwise require extensive routine supervision.
- These systems may be maintained on a monthly rental basis even if a member is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed two months following the admission month in accordance with public assistance policy.
- This service is available in the member's place of residence, excluding adult care homes.

MEDICATION REMINDER ENROLLMENT

Any company providing medication reminder services is eligible to enroll. Adult care homes are excluded from this service.

MEDICATION REMINDER REIMBURSEMENT

Procedure code is S5185.
One unit equals one month.

Note: The requirement for providers to use AuthentiCare 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. Providers may bill through AuthentiCare or to the MCO directly.

8400. BENEFITS AND LIMITATIONS Updated 10/17

NURSING EVALUATION VISIT

A Nursing Evaluation Visit is different from the initial assessment that is used to develop the POC. A Nursing Evaluation Visit is a service provided only to members that receive Level II PCS through a home health agency, assisted living facility, residential health care facility, or other licensed entity. A Nursing Evaluation Visit is conducted by an RN employed by the provider of Level II PCS. During the Nursing Evaluation Visit, the RN determines which PCS worker may best meet the needs of the member and any special instructions/requests of the member regarding delivery of services. This service includes an initial face-to-face evaluation visit by an RN, one time, per member, per provider. The following Level II PCS Health Maintenance Activities require an initial Nursing Evaluation Visit:

- Vital signs monitoring
- Supervision and/or training of nursing procedures
- Ostomy care
- Catheter care
- Enteral care
- Wound care
- Range of motion activities
- Changes in functions or condition reporting
- Medication administration and assistance

NURSING EVALUATION VISIT LIMITATIONS

- A Nursing Evaluation Visit will need to be completed for a member to access provider-directed Level II PCS Health Maintenance Activities.
- If a member chooses a home health agency that has provided nursing services to the member in the past and the agency is already familiar with the member's health status, a nursing evaluation visit is not required.
- This service must be provided by an RN employed, or a self-employed RN contracted, by the Personal Care Services Level II provider.
- A Nursing Evaluation Visit is not conducted when a member chooses to self-direct Personal Care Services (see the Personal Care Services Scope of Services Statement).
- The RN is responsible for submitting a written report to the member's MCO within two weeks of the visit. This report will include any observations or recommendations the nurse may have relative to the member which were identified during the Nursing Evaluation Visit.

NURSING EVALUATION VISIT ENROLLMENT

- County health departments
- Self-employed RNs licensed in Kansas
- The following entities licensed by KDHE:
  - Medicare-certified home health agencies
  - State-licensed home health agencies
- The following entities licensed by KDADS:
  - Home plus facilities
  - Assisted living facilities
  - Residential health care facilities

NURSING EVALUATION VISIT REIMBURSEMENT
Procedure code is T1001. One unit equals one face-to-face visit.

NURSING EVALUATION VISIT DOCUMENTATION REQUIREMENTS
Documentation is required for services provided and billed to KMAP. The nurse must provide the member's MCO with a written summary of the visit within two weeks of the visit. The written summary must, at a minimum, include the following:

- Identification of the waiver service being provided
- Member's name (first and last) and signature
- Nurse's name and signature with credentials
- Date of service (MM/DD/YY)
- Observations, interventions, teaching issues or instructions regarding delivery of services, etc.

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:

- Identification of the waiver service being provided (Nurse Evaluation Visit)
- Identification of the member receiving the service (first and last name)
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Nurse Evaluation Visit)
- Member's name (first and last) and signature
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Documentation must be generated at the time of the visit. Generating documentation after-the-fact is unacceptable. A sample of the HCBS FE Nursing Evaluation form is on the Forms page of the public and secure portals. It can be used to document HCBS FE services. Use of this specific form is not required, but it can be duplicated for your use.

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

PERSONAL EMERGENCY RESPONSE
Diagnosis alone does not determine need for this service. The member's MCO authorizes the need for this service based on an underlying medical or functional impairment.

This service does not duplicate other waiver services.

Personal emergency response units are electronic devices and have portable buttons worn by the member. These units provide 24-hour-a-day on-call support to the member having a medical or emergency need that could become critical at any time. Examples include:

- Potential for injury
- Cardiovascular condition
- Diabetes
- Convulsive disorders
- Neurological disorders
- Respiratory disorders

PERSONAL EMERGENCY RESPONSE LIMITATIONS

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of rental equipment is not covered.
- Rental, but not purchase, of this service is covered.
- Call lights do not meet this definition.
- This service is limited to those members who live alone, or who are alone a significant portion of the day in residential settings and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
- Once installed, these systems may be maintained on a monthly rental basis even if the member is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.
- Installation for each member is limited to twice per calendar year.

PERSONAL EMERGENCY RESPONSE ENROLLMENT
Any company providing personal emergency response systems is eligible to enroll.

PERSONAL EMERGENCY RESPONSE REIMBURSEMENT
Rental
One unit equals one month.
Procedure code is S5161.

Install
One unit equals one installation (maximum of two installations per calendar year).
Procedure code is S5160.

PERSONAL EMERGENCY RESPONSE DOCUMENTATION REQUIREMENTS

For the installation 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:

- Identification of the waiver service being provided (Personal Emergency Response Installation)
- Identification of the member receiving the service (first and last name)
- Identification of the installer
- Date of service (MM/DD/YY)
- Start time for the installation, include AM/PM or use 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For an installation service provided outside of a licensed adult care home and for those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Personal Emergency Response Installation)
- Member's name (first and last) and signature
- Identification of the installer and signature
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

For the monthly rental service, written documentation is not required.

Note: For members who have been notified by their MCO to receive services under ESD, the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 12/16

ENHANCED CARE SERVICES

Enhanced Care Services (ECS) are available to a member who demonstrates an assessed need for a minimum of six hours of sleep support within a 24-hour period. The assessed need cannot be met by use of a Personal Emergency Response System (PERS), informal support, or any other service such as 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.

Members in state custody cannot receive ECS.

Refer to the *HCBS Financial Management Services (FMS) Fee-for-Service Provider Manual* for additional information on responsibilities.

ENHANCED CARE SERVICES LIMITATIONS

- Only one unit (a minimum of six 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, RHCF, residential care facility (RCF), home plus, boarding care home, or residential supports for an individual with an intellectual and developmental disability (I/DD) that the member has selected as a provider.

ENHANCED CARE SERVICES continued

- 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 services, ECS workers must not be paid for services when another HCBS program service is being provided on the same time on the same day. For example, an ECS worker cannot provide services while a member is receiving PCS or is in therapy. The only exception is when justification for a two-person lift or transfer is documented on the ISP as necessary to meet the health and welfare needs of the member.
- ECS workers must not work or be paid for providing ECS, PCS, or any other HCBS program service for multiple HCBS program members at the same time.
- ECS must not duplicate any PCS provided through the HCBS program, Medicaid State Health, third-party entity, informal supports, or by any other method.
- ECS is provided as a crisis exception service if the member meets five of the six criteria below:
    - Lacks family or friends within close proximity to provide informal supports.
    - Has Adult Protective Service confirmation of self-neglect or abuse.
    - Lives in a rural or frontier area that is either more than 50 miles from any provider or the member lives alone.
    - Has a severe cognitive impairment.
    - Is in the end stages of an illness and is receiving hospice care.
    - Scores a "4" in toileting, transferring, medication management and treatment, and walking and mobility.
- No person residing in the same residence shall be paid to provide ECS unless an exception is identified and authorized by the MCO to mitigate risk of institutionalization, and the exception is documented on the ISP in accordance with appropriate limitations and exception.
- ECS cannot be provided by a member's legally responsible person (spouse or parent of a minor child) or any individual residing in the home with the member. However, exceptions may be authorized under one or more of the following conditions in accordance with the approved HCBS waivers:
    - The member lives in a rural area, in which access to a provider is beyond a 50-mile radius from the member's residence, and the relative or family member is the only provider available to meet the needs of the member.
    - The member lives alone and has a severe cognitive impairment, physical disability, or intellectual disability.
    - The individual has exhausted other support options by the MCO and without ECS would be at significant risk of institutionalization.

ENHANCED CARE SERVICES EXCEPTION TO LIMITATIONS

Conflict of Interest Policy

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

ENHANCED CARE SERVICES continued

- A guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest is mitigated.

Health Maintenance Activities

- In accordance with the Healing Arts Act and the Nurse Practice Act, Health Maintenance Activities can only be performed by a licensed physician or nurse.
  - Nursing assistance can be provided without delegation or supervision if provided for free by friends or members of the member's family (informal supports) as incidental care of the ill member by a domestic servant or in the case of an emergency.
  - Nursing assistance can be provided as part of PCS directed by a member or on behalf of a member in need of in-home care, when the nursing procedure has been delegated through a written physician or RN statement to a member who the physician or nurse knows or has reason to know is competent to perform those activities.
  - If authorized on the member's ISP, a licensed physician or nurse shall provide a written delegation for the following health maintenance activities:
    - Monitoring vital signs
    - Supervision and/or training of nursing procedures
    - Ostomy care
    - Catheter care
    - Enteral nutrition
    - Wound care
    - Range of motion
    - Reporting changes in functions or condition
    - Medication administration and assistance
- For agency-directed PCS workers:
  - An attendant who is a certified home health aide or a certified nurse aide shall not perform any health maintenance activities without delegation and supervision by a licensed nurse or physician pursuant to K.S.A. 65-1165.
  - A certified home health aide or certified nurse aide shall not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.
  - An agency shall maintain documentation of delegation by a licensed physician or nurse not employed by the agency. Agencies are responsible for ensuring appropriate supervision of delegated health maintenance activities.
  - Failing to properly supervise, direct, or delegate acts that constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols could result in discipline by the Board of Healing Arts.
- For self-directing members:
  - A member who chooses to self-direct care is not required to have the PCS supervised by a nurse or physician to perform health maintenance activities if both of the following apply:

ENHANCED CARE SERVICES continued

- Health maintenance activities can be provided without direct supervision. *". . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the member if the member were physically capable, and the procedure may be safely performed in the home."* K.S.A. 65-6201(d)
- Health maintenance activities and medication administration and assistance are authorized, in writing, by a physician or licensed professional nurse.

- The member's failure to properly supervise or direct health maintenance activities delegated to the member by a physician or licensed professional nurse could result in the termination of self-direction for those activities.

Medication Administration and Assistance

- Provided in a licensed facility
  - Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.
  - Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.
  - If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.
- Provided in a private residence
  - A KDHE-licensed or Medicare-certified Home Health Agency can provide nursing delegation to aides with sufficient training. The nurse delegation and training shall be specific to the particular member and his or her health needs. The qualified nurse retains overall responsibility.
  - Medicare-certified Home Health Agencies and state-licensed Home Health Agencies may perform medication administration and assistance in accordance with their licenses.
  - Self-directing members employing PCS workers who have a written physician's or registered nurse's statement to delegate health maintenance activities, including medication administration and assistance, are responsible to supervise PCS workers and train them to administer medication according to the physician's orders.

ENHANCED CARE SERVICES ENROLLMENT

To enroll, providers must meet the provider requirements for FMS. PCS workers must be referred to the enrolled FMS provider of the member's choice for completion of required human resources and payroll documentation.

ENHANCED CARE SERVICES PROVIDER REQUIREMENTS

ECS Workers

- 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.
- All ECS workers shall have all background check with no prohibited offenses prior to providing support services in accordance with the respective HCBS waiver requirements.

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.
- 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 REIMBURSEMENT

The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery, to provide consistency with other Medicaid services such as home health aide visits, and to meet the member preferences in providers and service delivery methods. Member health and safety and program cost-effectiveness will be monitored through case management. This will ensure providers deliver the necessary scope of services as agreed and defined in the plan regardless of the length of time needed to deliver the service.

ENHANCED CARE SERVICES DOCUMENTATION REQUIREMENTS

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 for both agency-directed and self-directed employers are required to use AuthentiCare Kansas. This is necessary to comply with federal requirements to ensure the health 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 time of the visit is not acceptable.
- Documentation must be clear and self-explanatory, or reimbursement may be subject to recoupment.
- Documentation must be uploaded to AuthentiCare Kansas by the FMS provider and in the member's file, as applicable.
- The applicable documentation must be maintained in the member's file and documented in the member's ISP, as appropriate.

ENHANCED CARE SERVICES continued

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 waiver service being provided (Enhanced Care Services)
- Identification of the member receiving the service (first and last name)
- Identification of the personal care services worker
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
- Stop time for each visit, include AM/PM or use 2400 clock hours

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Enhanced Care Services)
- Member's name (first and last) and signature on each page of documentation
- PCS worker's name and signature on each page of documentation
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours
- Stop time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Note: For members who have been notified by their MCO to receive services under ESD, the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

8400. BENEFITS AND LIMITATIONS Updated 07/24

WELLNESS MONITORING
This service provides a wellness monitoring visit through nursing assessment by a licensed nurse. This service provides an opportunity for the nurse to check a member's health concerns that have been identified by their MCO. This service reduces the need for routine physician/health professional visits and care in more costly settings. Any changes in the health status of the member during the visits are then brought to the attention of the MCO and the physician as needed. A written report must be sent to the MCO documenting the member's status within two weeks of the nurse visit.

This service includes:
- Nursing diagnosis
- Nursing treatment
- Counseling and health teaching
- Administration/supervision of nursing process
- Teaching of the nursing process
- Execution of the medical regimen

This service shall not duplicate other waiver services.

WELLNESS MONITORING LIMITATIONS
- Wellness monitoring is limited to one face-to-face visit every 55 days, or less frequently, as determined by the MCO.
- Wellness monitoring requires a written follow-up report within two weeks of the face-to-face visit by the licensed nurse. This report will be sent to the MCO regarding the findings and recommendation of the licensed nurse.
- When an LPN performs this service, the provider must ensure that the requirements of the Nurse Practice Act are met.

WELLNESS MONITORING ENROLLMENT
- County health departments
- The following entities licensed by KDHE:
  - Medicare-certified home health agencies
  - State-licensed home health agencies
- The following entities licensed by KDADS:
  - Home plus facilities
  - Assisted living facilities
  - Residential health care facilities
- Self-employed RNs licensed in Kansas

WELLNESS MONITORING REIMBURSEMENT
One unit equals one face-to-face visit.
Procedure code is S5190.

WELLNESS MONITORING DOCUMENTATION REQUIREMENTS
Documentation is required for services provided and billed to KMAP. The nurse must provide the MCO with a written summary of the visit within two weeks of the visit.

WELLNESS MONITORING continued

The written summary must, at a minimum, include the following:

- Identification of the waiver service being provided (Wellness Monitoring)
- Member's name (first and last) and signature
- Nurse's name and signature with credentials
- Date of service (MM/DD/YY)
- Clinical measurements, as needed, based on the member's presentation
- Review of systems, as needed, based on the member's presentation
- Additional observations, interventions, teaching issues, etc.

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:

- Identification of the waiver service being provided (Wellness Monitoring)
- Identification of the member receiving the service (first and last name)
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, include AM/PM or use 2400 clock hours
  For a postpayment review, reimbursement will be recouped if documentation is not complete.

For those limited instances where the member does not have telephone (landline or cell) access, written documentation must, at a minimum, include the following:

- Identification of the waiver service being provided (Wellness Monitoring)
- Member's name (first and last) and signature
- Identification of the nurse providing the service
- Date of service (MM/DD/YY)
- Start time for each visit, including AM/PM or using 2400 clock hours

For a postpayment review, reimbursement will be recouped if documentation is not complete.

Documentation must be generated at the time of the visit. Generating documentation after-the-fact is not acceptable. A sample of the HCBS FE Wellness Monitoring Log is on the public and secure portals. It may be used to document HCBS FE services. Use of this specific form is not required, but it may be duplicated for your use. Documentation must be clearly written and self-explanatory, or reimbursement may be subject to recoupment.

Note: For members who have been notified by their MCO to receive services under ESD, the services must be documented following the written documentation requirements until the Medicaid determination is made. Upon determination of Medicaid and HCBS FE eligibility notification, services must immediately be documented through the EV&M system, AuthentiCare Kansas. Claims for services previously rendered must be manually entered into AuthentiCare Kansas to be confirmed and processed for payment.

EXPECTED SERVICE OUTCOMES FOR INDIVIDUALS OR AGENCIES PROVIDING HCBS FE SERVICES

Updated 08/24

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

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

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

I. General Requirements

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

Updated 02/25

II. Adverse Incident Definitions

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

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

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

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

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

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

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

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

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

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.

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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 Person-Centered Service Plan (PCSP).
        i. The medication must be prescribed and approved by a licensed healthcare provider.
        ii. The approved use must comply with the policy established per the setting.
        iii. Medication administration must follow the member's PCSP.
        iv. Any prescribed medication with the intended purpose of altering a member's behavior as warranted by the current situation. A report is required when a prescribed medication is administered on an interval beyond or at a dosage above the routinely scheduled regimen as documented in the member's PCSP.
    b) Unauthorized Use of Chemical Restraint: Unauthorized use of chemical restraint is defined as the administration of any medication that is not authorized for use in the member's current PCSP.
        i. A report must be filed whenever medication is administered as a chemical restraint, as defined above, regardless of whether it is prescribed or over the counter. No reporting is necessary if the medication is administered within the confines of its prescription and is not used as a chemical restraint.

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 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.

Updated 11/21

IV. Definitions

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

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

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

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

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

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

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

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