TABLE OF CONTENTS

SECTION 3: COMMUNITY BASED SERVICES

3.4 Home and Community Based Services-Frail Elderly (HCBS/FE) - Services and Rates

3.4.1 HCBS/FE Services

Services provided are based upon needs identified through the Uniform Assessment Instrument (UAI) assessment process and included on the Plan of Care (POC). No services shall be provided prior to the choice date. Services shall be provided only after financial and functional eligibility have been determined and a POC Approver has authorized the POC.

The services available to HCBS/FE customers are:

1. Adult Day Care;
2. Assistive Technology;
3. Attendant Care Services;
4. Comprehensive Support;
5. Financial Management Services;
6. Home Telehealth;
7. Medication Reminder;
8. Nursing Evaluation Visit;
9. Oral Health Services
10. Personal Emergency Response;
11. Sleep Cycle Support; and
12. Wellness Monitoring.

Sleep Cycle Support is self-directed and Attendant Care Services and Comprehensive Support may be self-directed. If one or more services are self-directed, Financial Management Services must also be included on the POC.

3.4.1 (cont.)

A. ADULT DAY CARE

DEFINITION

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

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.

LIMITATIONS

Service may not be provided in the customer's own residence.

Customers living in an Assisted Living Facility, Residential Health Care Facility, or a Home Plus 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 customer 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 customer 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.

ENROLLMENT

Providers must be licensed by the Kansas Department on Aging (KDOA). Licensed entities include freestanding Adult Day Care Facilities, Nursing Facilities, Assisted Living Facilities, Residential Health Care Facilities, and Home Pluses.

3.4.1 (cont.)

B. ASSISTIVE TECHNOLOGY

DEFINITION

Assistive technology (AT) consists of:

- 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; or
- Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings.

LIMITATIONS

AT is limited to the customer's assessed level of service need, as specified in the customer's POC, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception in accordance with the established KDOA policies and guidelines.

All AT purchases require prior authorization from KDOA.

This service must be cost-effective and appropriate to the customer's needs.

This service is limited to a lifetime maximum of $7,500.

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 customer.

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 customer, the owner/landlord must agree in writing to maintain the modifications for the time period in which the HCBS/FE customer 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.

3.4.1.B (cont.)

External modifications (e.g. porches, decks, and landings) will only be allowed to the extent required to complete an approved request.

Home accessibility adaptations may not 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.

ENROLLMENT

Any business, agency, or company that furnishes assistive technology 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.

3.4.1 (cont.)

C. ATTENDANT CARE SERVICES

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

PROVIDER DIRECTED ATTENDANT CARE SERVICES

Attendant care services provide supervision and/or physical assistance with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) for individuals who are unable to perform one or more activities independently. (KSA 65-6201) Attendant care services may be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

There are three levels of provider directed attendant care services, which are referred to as Level I, Level II, and Level III. A combination of Level I (Service A & B) and Level II (Service C & D) can be utilized 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. For Boarding Care Homes, the tasks authorized on the POC must fall within the licensing regulations. Level III will be utilized in the development of the POC for those participants residing in adult care homes, excluding Boarding Care Homes.

Level I

Service A	Service B
Home Management of IADLs • Shopping • House cleaning • Meal preparation • Laundry	IADLs • Medication setup, cuing and reminding (supervision only)
	ADLs-attendant supervises the customer • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services

3.4.1.C (cont.)

ENROLLMENT

For Service **A** only-

- Non-medical resident care facilities licensed by the Kansas Department of Social and Rehabilitation Services (SRS).
- Entities not licensed by SRS, KDOA or the Kansas Department of Health and Environment (KDHE) must provide the following:
    - 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 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 Service **A or B**-

- County Health Departments
- The following entities licensed by KDHE:
    - Medicare Certified Home Health Agencies
    - State Licensed Home Health Agencies
- The following entities licensed by KDOA:
    - Boarding Care Homes.

3.4.1.C (cont.)

Level II
(An initial RN evaluation visit is necessary)

Service C	Service D
ADLs- physical assistance or total support • 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 nutrition • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance
	An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a Licensed Nurse.
	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.

3.4.1.C (cont.)

Level III
(An initial RN evaluation visit is necessary)

<table>
<tr>
<td>ADLs- Supervision, physical assistance, or total support
• Bathing
• Grooming
• Dressing
• Toileting
• Transferring
• Walking/Mobility
• Eating
• Accompanying to obtain necessary medical services</td>
<td>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</td>
</tr>
<tr>
<td>IADLs
• Shopping
• House cleaning
• Meal preparation
• Laundry
• Medication setup, cuing and reminding</td>
<td>An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a Licensed Nurse.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</table>

3.4.1.C (cont.)

Medication Administration in Licensed Facilities (KAR 26-41-205 and KAR 26-42-205)

1. 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.
2. 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.
3. 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 (KAR 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 shall be specific to the particular customer and their health needs. The qualified nurse retains overall responsibility.

ENROLLMENT

For Level II Service **C or D**-

- County Health Departments
- The following entities licensed by KDHE:
    - Medicare Certified Home Health Agencies
    - State Licensed Home Health Agencies

For Level III Services

- The following entities licensed by KDOA:
    - Home Pluses
    - Assisted Living Facilities
    - Residential Health Care Facilities

3.4.1.C (cont.)

LIMITATIONS (LEVEL I, II AND III)
Attendants must be 18 years or older.

Covered ADL and IADL services are limited as defined within the CSW and approved POC.

Attendant Care 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.

Attendant Care 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 customer'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 customer shall not be paid to provide Attendant Care for the customer. 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 in which the customer resides and the relative's relationship is within the second degree of the customer. (See KAR 26-41-101 and KAR 26-42-101 for regulatory requirements.)

This service shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.

More than one attendant will not be paid for services at any given time of the day; the only exception is when justification is documented on the CSW and the case log by the case manager for a two-person lift or transfer.

3.4.1.C (cont.)

SELF-DIRECTED ATTENDANT CARE SERVICES

Attendant care services provide supervision and/or physical assistance with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) for individuals who are unable to perform one or more activities independently. (KSA 65-6201) Attendant care services may be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

IADLs	ADLs	
• Shopping • House cleaning • Meal preparation • Laundry • Medication setup, cuing or reminding, and treatments	• 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 nutrition	• Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance	

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

According to KSA 65-1124(l), a customer who chooses to self-direct their care is not required to have their attendant care supervised by a nurse. Furthermore, KSA 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 Setup must be authorized, in writing, by a physician or an RN (AKA licensed *professional* nurse).

3.4.1.C (cont.)

ENROLLMENT

Providers must meet the provider requirements for Financial Management Services (FMS). Direct support workers must be referred to the enrolled FMS provider of the customer's choice for completion of required human resources and payroll documentation.

LIMITATIONS

Direct support workers must be 18 years of age or older.

A customer who has a guardian and/or conservator cannot choose to self-direct his or her attendant care; however, a guardian and/or conservator can make that choice on the ward's behalf.

A guardian, a conservator, a person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a customer cannot choose himself/herself as the paid direct support worker. If the designation of the appointed representative is withdrawn, the individual may become the customer's paid direct support worker after the next annual review or a significant change in the customer's needs occurs prompting a reassessment.

> EXCEPTION TO THIS LIMITATION: Customers 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 TCM shall complete a home visit at least every three (3) months to ensure that the selected direct support worker is performing the necessary services.

While a family member may be paid to provide attendant care, a customer's spouse shall not be paid to provide attendant care services unless one of the following criteria from KAR 30-5-307 are met and prior approval received from the KDOA TCM Program Manager:

1. three HCBS provider agencies furnish written documentation that the customer's residence is so remote or rural that HCBS services are otherwise completely unavailable;

2. two health care professionals, including the attending physician, furnish written documentation that the customer's health, safety, or social well-being, would be jeopardized (Note- documentation must contain how or in what way the customer's health, well-being, safety, or social well-being would be jeopardized);

3.4.1.C (cont.)

3. the attending physician furnishes written documentation that, due to the advancement of chronic disease, the customer's means of communication can be understood only by the spouse; or

4. three HCBS providers furnish written documentation that delivery of HCBS services to the customer poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable.

The Targeted Case Manager (TCM) and the customer or their representative will use discretion in determining if the selected direct support worker can perform the needed services.

Covered ADL and IADL services are limited as defined within the CSW and approved POC.

Attendant Care services are 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 shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.

More than one direct support worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the CSW and case log by the case manager for a two person lift or transfer.

A customer residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care Home has chosen that provider as his or her selected caregiver. These housing choices supersede the self-directed care choice.

3.4.1 (cont.)

D. COMPREHENSIVE SUPPORT

DEFINITION

Comprehensive Support is one-on-one, non-medical assistance, observation, and supervision provided to 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 support worker is present to supervise the customer and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example: read mail, books, and magazines or write letters) may also be provided.

Comprehensive Support is to be provided in the customer'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. Customers are given the option to self-direct their Comprehensive Support. A combination of service providers, either provider directed and/or self-directed, may be used to meet the approved POC.

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

LIMITATIONS

Comprehensive Support is limited to the customer's assessed level of service need, as specified in the customer's POC, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.

Support worker must be 18 years of age or older.

3.4.1.D (cont.)

Comprehensive Support is limited to a maximum of 48 units (12 hours) per day to occur during the customer's normal waking hours. Comprehensive Support in combination with other FE waiver services cannot exceed 24 hours per day.A customer 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 ward's behalf.

Under no circumstances shall a customer's spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a customer, be paid to provide Comprehensive Support for the customer.

For those customers self-directing, the Targeted Case Manager and the customer or their representative will use discretion in determining if the selected support worker can perform the needed services.

Customers residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, 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 customer.

This service is limited to those customers 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 Attendant Care Services or HCBS/FE Sleep Cycle Support.

This service shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.

ENROLLMENT FOR PROVIDER-DIRECTED COMPREHENSIVE SUPPORT:

- Medicare-certified or KDHE-licensed Home Health Agencies; Centers for Independent Living; County Health Departments; and Entities not licensed by SRS, KDOA, or KDHE.

3.4.1.D (cont.)

- Entities not licensed by SRS, KDOA, or KDHE must provide the following documentation:

    1. 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 shall provide written proof that it is authorized to do business in the state of Kansas.

    2. Written proof of liability insurance or surety bond.

ENROLLMENT FOR SELF-DIRECTED COMPREHENSIVE SUPPORT:

Providers must meet the provider requirements for FMS. Direct support workers must be referred to the enrolled FMS provider of the customer's choice for completion of required human resources and payroll documentation.

3.4.1 (cont.)

E. FINANCIAL MANAGEMENT SERVICES

DEFINITION

Financial Management Services (FMS) is provided for customers who are aging or disabled and will be provided within the scope of the Agency with Choice (AWC) model. Within the self-directed model and Kansas state law (K.S.A. 39-7,100), customers have the right to "make decisions about, direct the provisions of and control the attendant care services received by such individuals including, but not limited to selecting, training, managing, paying and dismissing a direct support worker." The customer or customer's representative has decision-making authority over certain services and takes direct responsibility to manage these services with the assistance of a system of available supports. FMS is included in these supports.

The AWC FMS is the employer-option model Kansas has available to customers who reside in their own private residence or the private home of a family member and have chosen to self-direct some or all of their services. The customer or his or her representative has the right to choose this employer-option model and the right to choose from qualified available FMS providers. This information must be made available at the time of making the choice to self-direct services and annually thereafter. The FMS provider must be listed on the POC and the administrative functions of the FMS provider are reimbursed as a waiver service. (See Sec. 3.5.9.B)

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

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

Once fully informed, the customer or customer's representative must negotiate, review, and sign an FMS Service Agreement developed and made available by the State of Kansas and distributed by the FMS provider. The FMS Service Agreement will identify the "negotiated" role and responsibilities of both the customer and the FMS provider. It will specify the responsibilities of each party.

3.4.1.E (cont.)

Information and Assistance has been incorporated into the definition and requirements of the FMS provider:

- Information and Assistance (I&A) is a service available to provide information, including independent resources, and assistance in the development of options to ensure customers understand the responsibilities involved with directing their services. Practical skills training is offered to enable self-directing customers, their families, and/or representatives to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring direct support workers, managing workers, effectively communicating, and problem-solving. The extent of the assistance furnished to the self-directing customer will be determined by the self-directing customer or customer's representative.

- I&A services may include activities that nominally overlap with the provision of information concerning self-direction provided by a case manager. However, this overlap does not allow the FMS provider to be involved in the development of the CSW and/or other planning documents or assessments.

- I&A services may provide assistance to the self-directed customer or customer's representative with:
    - Defining goals, needs, and resources
    - Identifying and accessing services, supports, and resources as they pertain to self-directed activities
    - Learning practical management skills training (such as hiring, managing, and terminating workers; problem solving; conflict resolution)
    - Recognizing and reporting critical events (such as fraudulent activities, abuse)
    - Managing services and supports

3.4.1.E (cont.)

- I&A services may provide information to the self-directing customer or customer's representative about:
  - Individual-centered planning
  - Range and scope of customer's choices and options
  - Grievance and appeals processes
  - Risks and responsibilities of self-direction
  - Individual rights
  - Importance of ensuring direct support worker's (DSW) health and safety during the course of his or her duties to reduce potential injuries and worker's compensation insurance claims

    Note: This may include participation in training as directed by the self-directing customer.
  - Reassessment and review schedules
  - Importance of keeping the FMS provider agency and TCM informed with current contact information and planned absences
  - Other subjects pertinent to the customer and/or family in managing and directing services and living independently and safely in the community in the most integrated setting

- The Kansas "Self-Direction Tool Kit" is recommended as a resource for I&A.

- The I&A services a customer chooses to access must be outlined in a service agreement that identifies what support a self-directing customer may want or need.

LIMITATIONS

The customer or customer's representative cannot receive payment for the administrative functions he or she may perform.

Only one FMS provider is to be authorized on a POC per month.

Access to this service is limited to customers or their representatives who direct some or all of their services.

3.4.1.E (cont.)

ENROLLMENT

Each potential Agency with Choice Financial Management Services (FMS) entity must meet the following requirements:

1. SRS/KDOA Provider Agreement
   a. Applications are available on the following website: http://www.srs.ks.gov/agency/css/Pages/default.aspx or www.aging.ks.gov.
   b. The application must be completed and returned as identified on the website.
   c. Application must be complete. Incomplete applications or the failure to provide required documentation will result in the application being pended awaiting completed documentation.
   d. SRS/KDOA Provider Agreements are valid for three (3) years unless revoked, withdrawn or surrendered.
2. Medicaid Provider Agreement
   a. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved SRS/KDOA provider agreement.
   b. Medicaid provider requirements can be located at: https://www.kmap-state-ks.us.
3. Registration with the Secretary of State's office, if required, including the following:
   a. Be in good standing with all Kansas laws/business requirements.
   b. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
   c. Owner, primary operator and administrator of FMS business must live in a separate household from individuals receiving services from the FMS business.
   d. Business is established to provide FMS to more than one individual.
4. Insurance defined as:
   a. Liability insurance with a $500,000 annual minimum
   b. Workers Compensation Insurance
      i. Policy that covers all workers
      ii. Meets all requirements of the State of Kansas
      iii. Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
   c. Unemployment insurance (if applicable)
   d. Other insurances (if applicable)

3.4.1.E (cont.)

5. Annual Independent Financial Audit
6. Demonstrate financial solvency
   a. Evidence that 30 days coverage of operation costs are met (cash requirements will be estimated utilizing the past quarter's performance from the date of review or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).
   b. Evidence may include the following:
      i. Cash (last three bank statements)
      ii. Open line of credit (statement(s) from bank/lending institution)
      iii. Other (explain)
7. Maintain required policies/procedures including, but not limited to;
   a. Policies/procedures for billing Medicaid, in accordance with approved rates, for services authorized by Plan of Care (POC).
   b. Policies/procedures for billing FMS administrative fees
   c. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports
      i. Semi-annual reports to self-direct individuals for billing/disbursements on their behalf
      ii. Report to the State of Kansas, as requested
   d. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and DSW) in accordance with program requirements
   e. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures established by the State of Kansas when setting DSW's pay rates.
      i. Clear identification of how this will occur
      ii. Prohibition of wage/benefit setting by FMS provider
      iii. Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/participants and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.

3.4.1.E (cont.)

f. Policies/procedures that ensure proper/appropriate process of timesheets, disbursement of pay checks, filing of taxes and other associated responsibilities
g. Policies/procedures regarding the provision of Information & Assistance services
h. Policies/procedures for Grievance. The Grievance Policy is designed to assure a method that DSWs can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other FMS-related issues.

3.4.1 (cont.)

F. HOME TELEHEALTH

DEFINITION

Home telehealth is a remote monitoring system provided to a customer that enables the customer to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the customer's health declines. The provision of home telehealth entails customer education specific to one or more diseases, counseling, and nursing supervision.

Home telehealth automates disease management activities, and engages customers with personalized daily interactions and education to build or expand the customer's self-management behaviors. The service will enable telehealth providers, after determining the customer's progress, to motivate behavior changes through user-friendly technology, helping customers meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.

The provider will access the telehealth system to review each customer's baseline, defined by the customer's physician at enrollment, trended survey responses, and vital sign measurements. A licensed nurse will monitor the health status of multiple customers, and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional.

Customers qualify for this service if the customer:

- is in need of disease management consultation and education; and
- has had two or more hospitalizations, including ER visits, within the previous year related to one or more diseases; or
- is using Money Follows the Person to move from a nursing facility back into the community.

The provider must train the customer and caregiver on use of the equipment. The provider must also ensure ongoing customer education specific to one or more diseases, counseling, and nursing supervision. Customer education shall include such topics as learning symptoms to report, the disease process, risk factors, and other relevant aspects relating to the disease.

HCBS/FE home telehealth services is not a duplication of Medicare telehealth services. While the Kansas legislature calls this service home telehealth, the actual service follows the CMS telemonitoring definition which Medicare does not cover. HCBS/FE home telehealth is a daily monitoring of the customer's vital sign measurements from the customer's home setting to prevent a crisis episode; whereas Medicare telehealth includes specific planned contacts for professional consultations, office visits, and office psychiatry services, usually through video contact.

3.4.1F (cont.)

During KDOA's plan of care approval process, KDOA will confirm there is no prior authorization for Medicaid home telehealth skilled nursing visits in the Medicaid

Management Information System (MMIS). If a prior authorization is identified, HCBS/FE home telehealth services will be denied.

LIMITATIONS

Registered Nurse (RN) or licensed practical nurse with RN supervision to set up/ supervise/provide customer counseling.

Customer must have a landline or wireless connection.

Installation required within 10 working days of approval.

Maximum of two installations per calendar year.

Monthly status reports to the physician and case manager.

Minimum monthly customer contact, to reinforce positive self-management behaviors.

If customer fails to perform daily monitoring for seven (7) consecutive days, case manager must be notified to determine if continuation of the service is appropriate.

Customers living in an Assisted Living Facility, Residential Health Care Facility, or a Home Plus are not eligible for this service.

ENROLLMENT

- County Health Departments
- The following entities licensed by KDHE:
    - Medicare Certified Home Health Agencies
    - State Licensed Home Health Agencies

3.4.1 (cont.)

G. MEDICATION REMINDER

DEFINITION
A Medication Reminder System provides a scheduled reminder to a customer when it's time for him/her to take medications. The reminder may be a phone call, an automated recording, or an automated alarm, depending on the provider's system.

This service does not duplicate other waiver services.

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.

This service is limited to those customers who live alone, or who are alone a significant portion of the day and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.

These systems may be maintained on a monthly rental basis even if the customer 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.

This service is available in the customer's place of residence, excluding adult care homes.

ENROLLMENT
Any company providing Medication Reminder Services is eligible to enroll. Adult Care Homes are excluded from this service.

3.4.1 (cont.)

H. NURSING EVALUATION VISIT

DEFINITION

A Nursing Evaluation Visit is different from the initial assessment that is used to develop the POC. Nursing Evaluation Visit is a service provided only to customers that receive Level II Attendant Care Services through a Home Health Agency, Assisted Living Facility, Residential Health Care Facility, or other licensed entity. Nursing Evaluation Visits are conducted by an RN employed by the provider of Level II Attendant Care Services. During the Nursing Evaluation Visit, the RN determines which attendant may best meet the needs of the customer, and any special instructions/requests of the customer regarding delivery of services.

This service includes an initial face-to-face evaluation visit by an RN, one time, per customer, per provider.

LIMITATIONS

A Nursing Evaluation Visit will need to be completed for a customer who needs provider-directed Attendant Care Services Level II.

If a customer chooses a home health agency that has provided nursing services to the customer in the past, and the agency is already familiar with the customer's health status a Nursing Evaluation Visit is not required.

This service must be provided by an RN employed by, or a self-employed RN contracted by, the Attendant Care Level II provider.

A Nursing Evaluation Visit is not conducted when a customer chooses to self-direct Attendant Care Services (see the Attendant Care Scope of Services Statement).

The RN is responsible for submitting a written report to the TCM within two weeks of the visit. This report will include any observations or recommendations the nurse may have relative to the customer which were identified during the Nursing Evaluation Visit.

ENROLLMENT

- County Health Departments
- Self-Employed Registered Nurses licensed in Kansas
- The following entities licensed by KDHE:
    - Medicare Certified Home Health Agencies
    - State Licensed Home Health Agencies
- The following entities licensed by KDOA:
    - Home Pluses
    - Assisted Living Facilities
    - Residential Health Care Facilities

3.4.1 (cont.)

I. ORAL HEALTH SERVICES

DEFINITION
Oral Health Services shall mean accepted dental procedures, to include diagnostic, prophylactic, and restorative care, and allow for the purchase, adjustment, and repair of dentures, which are provided to adults (age 65 and older) who are enrolled in the HCBS/FE waiver. Anesthesia services provided in the dentist's office and billed by the dentist shall be included within the definition of Oral Health Services.

LIMITATIONS
Oral Health Services are limited to the customer's assessed level of service need, as specified in the customer's POC, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception in accordance with the established KDOA policies and guidelines.

To avoid duplication of services, Oral Health Services only include needed services not covered by regular State Plan Medicaid, and are limited to those services which cannot be procured from other formal or informal resources such as community donations received by the case management entity (CME) to use toward oral health services, other formal programs funded from state general funds, and Medicare 65 plans.

Services shall not include outpatient or inpatient facility care.

Orthodontic and implant services are not covered.

Complete or partial dentures are allowed once every 60 months.

Provision of Oral Health Services for cosmetic purposes is not a covered service.

ENROLLMENT
Dentists and dental hygienists licensed to practice in the state of Kansas are eligible to enroll.

3.4.1 (cont.)

J. PERSONAL EMERGENCY RESPONSE

DEFINITION

Diagnosis alone does not determine need for this service. The TCM 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 customer. These units provide 24 hour a day on-call support to the customer having a medical or emergency need that could become critical at anytime.

Examples include:

- Potential for Injury
- Cardiovascular Condition
- Diabetes
- Convulsive Disorders
- Neurological Disorders
- Respiratory Disorders

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 customers 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 customer 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 customer is limited to twice per calendar year.

ENROLLMENT

Any company providing personal emergency response systems is eligible to enroll.

3.4.1 (cont.)

K. SLEEP CYCLE SUPPORT

DEFINITION
This service provides non-nursing physical assistance and/or supervision during the customer's normal sleeping hours in the customer's place of residence, excluding adult care homes. This service includes physical assistance or supervision with toileting, transferring and mobility, and prompting and reminding of medication. This service shall not duplicate other waiver services.

Direct support worker may sleep but must awaken as needed to provide assistance as identified in the customer's service plan. Direct support worker must provide the customer a mechanism to gain their attention or awaken them at any time. Direct support worker must be ready to call a physician, hospital or other medical personnel should an emergency arise. Direct support worker must submit a report to the TCM within the first business day following any emergency response provided the customer.

Sleep Cycle Support is a self-directed service. The customer or representative is responsible for making choices about sleep cycle support, including the referring for hire, supervising and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

LIMITATIONS
Sleep Cycle Support is limited to the customer's assessed level of service need, as specified in the customer's POC, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.

Direct support workers must be 18 years of age or older.

Period of service must be at least six hours in length but cannot exceed a twelve-hour period of time.

Only one unit is allowed within a 24-hour period of time.

Sleep Cycle Support in combination with other HCBS/FE waiver services cannot exceed 24 hours per day.

Under no circumstances shall a customer's spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a customer be paid to provide Sleep Cycle Support for the customer.

3.4.1.K (cont.)

Customers residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care Home are not eligible for this service.

Direct support worker must have a permanent residence separate and apart from the customer.

The TCM and the customer or their representative will use discretion in determining if the selected direct support worker can perform the needed services.

This service shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.

ENROLLMENT
Providers must meet the provider requirements for Financial Management Services (FMS). Direct support workers must be referred to the enrolled FMS provider of the customer's choice for completion of required human resources and payroll documentation.

3.4.1 (cont.)

L. WELLNESS MONITORING

DEFINITION

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 customer's health concerns that have been identified by the TCM. 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 customer during the visits are then brought to the attention of the TCM and the physician as needed. A written report must be sent to the TCM documenting the customer's status within two (2) 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.

LIMITATIONS

Wellness Monitoring is limited to one face-to-face visit every 55 days or less frequently, as determined by the TCM.

Wellness Monitoring requires a written follow-up report within two (2) weeks of the face-to-face visit by the licensed nurse. This report will be sent to the TCM regarding the findings and recommendation of the licensed nurse.

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 KDOA:
    - Home Pluses
    - Assisted Living Facilities
    - Residential Health Care Facilities
- Self-employed Registered Nurses licensed in Kansas.

3.4.2 HCBS/FE Rates

Code	Service	Rate	MMIS Billing Code
MADCX	Adult Day Care (Unit = 1 to 5 hours) Limited to two units per day	Unit Cost = $21.93 Maximum per day Cost = $43.86	S5101
ASTEX	Assistive Technology (Unit = $1.00)	Lifetime Maximum Cost = $7,500	T2029
ATCR1X (Level I);	Attendant Care Services – Provider Directed (Unit = 15 minutes)	Unit Cost = $3.38	S5130
ATCR2X (Level II)	Attendant Care Services – Provider Directed (Unit = 15 minutes)	Unit Cost =$3.73	S5125
ATCR3X (Level III)	Attendant Care Services – Provider Directed (Unit = 15 minutes)	Unit Cost = $4.12	S5125 UA
ATCRUD	Attendant Care Services – Self-Directed (Unit = 15 minutes)	Unit Cost = $2.71	S5125 UD
COMPX	Comprehensive Support – Provider Directed (Unit = 15 minutes)	Unit Cost = $3.38	S5135
COMPUD	Comprehensive Support – Self-Directed (Unit = 15 minutes)	Unit Cost = $2.71	S5135 UD
TELEIX (install) TELEX (rental)	Home Telehealth (Unit = 1 day)	Installation (Limit twice per calendar year) = $70.00 Unit Cost = $6.00	Install: S0315 Daily: S0317
FMSSDX	Financial Management Services (Unit = 1 month)	Unit Cost = $115.00	T2040 U2
MEDRX	Medication Reminder (Unit = 1 month)	Unit Cost = $15.91	S5185
NUEVX	Nursing Evaluation Visit (Unit = 1 face-to-face visit)	Unit Cost = $39.37	T1001
N/A	Oral Health Services (Unit = $1.00)	Unit Cost = $1.00	Refer to MMIS Procedure Code List
PERMIX (install); PERMX (rental)	Personal Emergency Response (Unit = 1 month)	Installation (Limit twice per calendar year) = $56.25 Unit Cost = $26.52	Install: S5160 Monthly: S5161
MASCX	Sleep Cycle Support (Unit = 6 to 12 hours)	Unit Cost = $22.44	T2025
MAWMX	Wellness Monitoring (Unit = 1 face-to-face visit)	Unit Cost = $39.37	S5190