

**KANSAS DEPARTMENT ON AGING  
FIELD SERVICES MANUAL**

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### **3.1 Case Management Services**

#### **3.1.1 Introduction and Definition**

Case management (CM) consists of providing assistance in access and coordination of information and services to older customers and/or their caregivers to support the customers in the living environment of their choice. CM services funded by Older Americans Act (OAA) Title III B and by Senior Care Act (SCA) through the Kansas Department for Aging and Disability Services (KDADS) are subject to an annual grant and/or contract process.

Case managers providing CM services shall comply with KDADS regulations and policies, both current and as amended in the future.

#### **3.1.2 Targeted Population**

- A. Older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). [OAA Section 305(a)(2)(E)]
- B. Individuals assessed and referred pursuant to KSA 39-968 (CARE Program) who reside in the community and can function independently with the assistance of community based services;
- C. Individuals to be discharged from hospitals and nursing homes to the community and needing services; and
- D. Residents of long term care facilities who are able to return to their home or other community-based setting if services are provided to them.

#### **3.1.3 Customer Eligibility**

- A. Individuals must meet the following requirements to be eligible for CM funded by OAA and SCA:
  - 1. The customer must be 60 years of age or older;
  - 2. The customer must have been assessed using the form designated by KDADS;
  - 3. For SCA customers only, the customer must meet Long Term Care Threshold criteria established for SCA;
  - 4. The customer has a need identified by the state designated assessment form for CM to be funded by the OAA and/or SCA funding sources.

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5. Short term CM services are available for customers receiving one time services for period of 90 days. CM services beyond the 90 day period for customers receiving one time services can be provided with approval from KDADS SCA/OAA Program Manager.
6. The customer is unable to obtain, coordinate, and monitor the required services for himself or herself without assistance; and
7. The customer does not have a designated person acting on their behalf that is able and willing to provide adequate coordination and monitoring of services.

#### 3.1.4 Case Manager Qualifications

- A. CM funded by OAA or SCA shall be provided by either employees or contractors of an Area Agency on Aging (AAA) recognized by KDADS.
- B. Case management shall be provided by individuals that have participated in all training stipulated in Section 3.1.6, Training and Certification Requirements, to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by the state agency administering the program.
- C. A case manager employed by, or under contract with, an AAA cannot also be employed by, or under contract with, any entity which creates a conflict of interest by providing OAA and/or SCA services.
- D. A Case Manager must meet the following qualifications:
  1. An individual with a four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, or family studies, or related area as approved by KDADS SCA/OAA Program Manager, and that individual has at least one (1) year experience in the aging and /or disability field; or
  2. A Registered Professional Nurse licensed to practice in the State of Kansas with at least one (1) year experience in the aging and/or disability field; or
  3. An individual providing CM services through an AAA prior to September 30, 2015 shall be deemed as meeting education and experience requirements.

A Junior I Case Manager must meet the following qualifications:

4. An individual with a High School or General Education Diploma and four (4) years work experience in the human services field with an emphasis in aging services; or a combination of work experience in the human services field and post-secondary education, with

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one (1) year of work experience substituting for one (1) year of education (an individual that meets the senior case manager qualifications must supervise this person).

A Junior II Case Manager must meet the following qualifications:

5. An individual with a High School or General Education Diploma and one (1) year work experience (an individual that meets the senior case manager qualifications must supervise this person).

**3.1.5 Components of Case Management:**

Component	Senior Case Manager Qualification Required	Junior Case Manager Qualification Allowed
<b>A. Assessment</b>		
1. Assess an eligible individual to determine service needs, including:		
a) taking customer history;	Yes	No
b) identifying the individual's needs and completing the assessment instrument designated by KDADS and related documentation; and	Yes	No
c) gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.	Yes	No
2. Documenting all pertinent information related to tasks completed.	Yes	No
<b>B. Development of a Plan of Care (POC)</b>		
1. Develop a plan of care that:		
a) is based on the information collected through the assessment via a completed Customer Service Worksheet (CSW);	Yes	No
b) specifies the goals and actions to address the medical, social, education, and other service needs of the individual;	Yes	No
c) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized	Yes	No

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d) health care decision maker) and others to develop such goals, and identify a course of action to respond to the assessed goals and needs of the eligible individual; and		
e) includes time spent discussing service options and alternatives, needs, and preferences of the customer, services to be provided, authorized costs, and the implementation dates.	Yes	No
2. Documenting all pertinent information related to tasks completed.	Yes	No

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Component	Senior Case Manager Qualification Required	Junior Case Manager Qualification Allowed
<b>C. Referral and Related Activities</b>		
1. Help an individual obtain needed services, including:		
a) activities that help link the individual with medical, social, or educational providers; or	Yes	No
b) activities that help link the individual with other programs and services that are capable of providing needed services, such as making referrals to providers for needed services.	Yes	No
c) assist with application(s) for other programs, such as but not limited to QMB, LMB, SNAP, and HCBS.	Yes	No
2. Report to Department of Children and Families (DCF) Adult Protective Services (APS) and/or law enforcement any suspected abuse, neglect, or exploitation of the individual.	Yes	Junior I and Junior II Case Manager
3. Expanding the service options available by encouraging the informal supports and formal service providers to be more flexible, and also seeking new or non-traditional resources and services.	Yes	No
4. Promoting the enrollment of new providers on behalf of individuals.	Yes	No
5. Documenting all pertinent information related to tasks completed.	Yes	Junior I Case Manager only
<b>D. Monitoring and Follow-up Activities</b>		
1. Activities and contacts that are:		
a) necessary to ensure the POC is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities; and	Yes	Junior I Case Manager only

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b) conducted as defined in Section 3.1.8.B to determine whether: <ul style="list-style-type: none"> <li>• services are being furnished in accordance with the individual’s POC;</li> <li>• the services in the POC are adequate; and</li> <li>• there are changes in the needs or status of the individual, and if so, making necessary adjustments in the POC and service arrangements with the providers.</li> </ul>	Yes	No
2. Ensuring public and private resources are used efficiently to meet the health and welfare needs of the individual as set forth in the POC.	Yes	No
3. Documenting all pertinent information related to the tasks completed.	Yes	Junior I Case Manager Only

**3.1.6 Training and Certification Requirements**

A. All case managers must meet the training and certification requirements for assessors (Section 2.7) prior to completing any component of the assessment designated by KDADS.

B. All case managers must complete the following:

1. Comprehensive Case Management (CCM) training provided by the KDADS within three (3) months of the start of their employment or contract or first available KDADS training;
2. All KDADS mandated CCM, UAI, and Kansas Aging Management Information System (KAMIS) training programs on an ongoing basis; KAMIS training requirements shall be waived upon KDADS receipt of a letter from the AAA’s director stating the case managers will not be required to enter information into KAMIS; and



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3. A total of 15 hours of continuing education on an annual basis (the 15 hours includes CCM training), with an emphasis in aging and/or disability topics.

### 3.1.7 Skills Requirements

- A. Case managers must have the following knowledge, skills and abilities:
  1. Conflict resolution;
  2. Time management skills;
  3. Ability to effectively communicate with customers, family members, service providers, and co-workers;
  4. Ability to initiate and sustain effective interpersonal relationships;
  5. Knowledge of community resources and available funding sources;
  6. Knowledge of quality of services recommended;
  7. Have a thorough and current knowledge of the community based service system in their service area;

### 3.1.8 General Case Management Standards

- A. Personnel
  1. Only qualified individuals may provide CM services.
  2. Case managers must receive the required number of training hours.
  3. AAAs must have procedures that address how case managers will be supervised and their work monitored.
  4. Volunteers and family members may not receive reimbursement for CM services.
- B. Case Management Services
  1. Only eligible customers per 3.1.3.A may receive CM services.
  2. Implementation of services shall occur within seven (7) working days following the determination of eligibility and referral for the services, unless otherwise requested by the customer or their family.

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3. There shall be evidence that the customer and the customer's family members are educated on how to manage their own needs, with an ultimate goal of empowering customer/family independence to advocate for themselves, whenever possible.
4. Case managers shall make every effort to utilize/access all available services to meet the needs of their customers, not just those funded by the AAA.
5. Ongoing evaluation and monitoring shall occur on a regular basis to assure services are being provided according to the POC and CSW, timely referrals are made on behalf of the customer; and
  - a. CMs are required to make contact with the customer or the customer's representative for monitoring purposes on a quarterly basis, at a minimum, including two face-to-face visits with each customer annually or as otherwise required to meet customer's needs or as related to policy changes
6. Utilization of informal and formal resources is coordinated in a cost-effective manner so that there is a continual decrease in the number of unmet service needs experienced by the customer.
7. Documentation accurately reflects customer health status, service provision, choice of providers and coordination of services in accordance with the POC and CSW. Documentation also adheres to KDADS policies as set forth in the Field Services Manual and state and federal rules, regulations, and requirements.
8. Each suspected incidence of abuse, neglect, or exploitation (ANE) must be reported to DCF Adult Protective Services (APS) or KDADS Licensure, Certification, and Evaluation (LCE), as appropriate. The report date and appropriate ANE taxonomy code must be documented on the KAMIS POC within 3 working days of making the report. Once the determination is received from APS or LCE, the applicable closure code must be entered on the KAMIS POC.
9. Documented travel time is a reimbursable expense for CM services rendered under SCA only.
10. Transfer of customer files between AAAs within Kansas;
  - a. Transferring AAA shall, upon notification of customer relocation from PSA and desire of customer to continue services, contact receiving AAA to determine availability of services and notification of customer relocation.
  - b. Transferring AAA shall provide receiving AAA, at minimum, last 6 months of case file and complete customer transfer in state designated MIS.

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- c. Receiving AAA shall make contact with customer and set up service or discuss waitlist procedures within 7 working days of customer transfer.

### 11. Quality Assurance

- a. Customer case files will be randomly monitored by KDADS quality review staff quarterly to determine compliance with customer-based performance criteria.
- b. Customers must be informed of their rights and responsibilities at every face to face customer/family visit and on every Notice of Action. This must be documented in each customer's case file.
- c. Customer Fee Agreement, Customer Code of Conduct, Customer Service Worksheet and Customer Choice Forms are reviewed and signed annually and documented in customer case file.
- d. Activated Durable Power of Attorney (DPOA) and/or Legal Guardianship shall be documented in customer case file.
- e. The AAA shall develop and implement an independent complaint mechanism; this shall be available upon request in a written document.

12. CM shall be available in the entire Planning and Service Area (PSA) for the OAA and SCA programs.

13. Customers shall receive OAA or SCA CM services from the AAA responsible for the PSA in which the customer resides. When possible, each AAA shall provide the customer choice of case manager within the agency.

### 3.1.9 Service Limitations

- A. SCA and OAA CM cannot be provided in conjunction with any other case management service.
- B. CM does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- C. The case manager may assist the customer with the appeal process, as requested. The case manager may explain how a customer seeks review of a program decision or may provide an appropriate form for the customer to use when requesting a hearing. During the hearing, the customer may be represented by any person or attorney as long as the representative is not the case manager or any other individual employed by, or under contract with, the AAA.
- D. Customer eligibility as defined by FSM 3.1.3.

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**3.1.10 Billing**

A. Accounting For and Recording Time

1. AAAs shall accurately account for their time spent working on, and recording in, individual customer's case records.
2. AAAs shall not submit bills claiming payment for time not actually spent in providing CM services or time spent during the Quality Review process.
3. A unit of service for CM is 15 minutes.
4. CM shall be billed by units or partial units of service as outlined below:
  - a. 0.5 unit = 0.1 through 7.50 minutes of CM services
  - b. 1 unit = 7.51 through 15.00 minutes of CM services

Time performing CM services beyond one unit shall be recorded and billed in the same way.

5. If multiple case managers consult on a customer's case, their total units of service may be billed.
6. When an individual is employed in a CM supervisory capacity and is current with all training and certification requirements, they may bill their consulting time with case managers.

B. Required Documentation

1. Each AAA shall develop and implement a systematic customer case file organization within their agency and maintain that same system of organization for each individual case file.
2. Providers of CM services are required to maintain individual case files that indicate all contacts with and on behalf of customers. These case files shall include the following information and shall be available for review by state and federal agencies:
  - a. The complete legal name of the individual receiving the service;
  - b. The date the service was provided (mm/dd/yyyy);
  - c. The name of the AAA;
  - d. The name of the case manager providing the service;
  - e. The name of the contact and relationship to customer;
  - f. The location of the service provided;
  - g. The component of case management service provided under Section 3.1.5;

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- h. Documentation content must include description of discussion and/or action taken with or on behalf of customer and include any follow up required;
    - i. The amount of time provided, in units or partial units, per customer;
    - j. The individual providing the CM services must initial each case log entry and sign each page of the case log.
3. Using these records as documentation, the AAA shall then bill the KDADS, as directed. The CM shall only bill for documentation to one case file.

### 3.1.11 Case Manager Safety and Welfare

- A. Each case manager should be able to work in an environment free from threats, threatening behavior, acts of violence, or any other related conduct which disrupts the ability to execute the performance of his or her duties.
- B. Each customer shall annually agree to sign and abide by the “Customer Code of Conduct”.
- C. The AAA’s response to safety offenses shall depend on the nature and degree of the offense.
- D. This policy does not supersede statutory and regulatory licensure requirements for licensed nurses, licensed social workers, or other professionals licensed in Kansas.
- E. The AAA shall establish criteria to determine if the case manager is to be accompanied by another employee or a law enforcement official. If another employee is sent, only one may bill for CM services.
- F. Level I Safety Offense
  1. The following are considered Level I Safety Offenses. If an offense occurs, the case manager shall document the offense in the customer’s case log. In addition, the case manager may choose to file a written report with their AAA for further action:
    - a. Verbal harassment toward the case manager, including yelling or demanding behavior;
    - b. Making inappropriate remarks or physical actions toward the case manager that may be considered racist, discriminatory, or sexual in nature;
    - c. Possession of unauthorized materials such as explosives, illegal weapons, or other similar items while in the presence of the case manager;
    - d. Manufacturing, use, or distribution of illegal drugs while in the presence of the case manager; or
    - e. Possession of a legal firearm in the presence of the case manager, when that firearm is not securely stored in a safe location.

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2. A written report of a Level I Safety Offense shall result in the following actions:
  - a. The AAA shall provide the case manager with alternative solutions to address the inappropriate behavior or circumstances.
  - b. The AAA shall then attempt to resolve the situation by consulting with the case manager and the customer.
  - c. If the situation remains unresolved, the AAA and the case manager shall develop a written action plan, taking customer input into consideration, as appropriate.
  - d. If the customer fails to comply with the action plan and the situation remains unresolved, CM services may be terminated following a timely notice of action to the customer. Loss of CM services shall result in the following:
    - i. Termination of all OAA/SCA services;
    - ii. Option to self-direct SCA services will no longer be available; and
    - iii. Possible termination of services funded by other sources.
  - e. At the time of service termination, a copy of the written report identifying the offense, the action plan, documentation in the customer's case log, and the customer's notice of action shall be submitted to the KDADS OAA/SCA Program Manager.

### G. Level II Safety Offenses:

1. The following are considered Level II Safety Offenses. If an offense occurs, the case manager shall document the offense in the customer's case log. In addition, the case manager shall provide a written report to their AAA for further action:
  - a. Verbal threat or other behavior toward the case manager that insinuates physical harm;
  - b. Sexual assault of the case manager;
  - c. Physical contact with the case manager resulting in bodily harm; or
  - d. Use of a firearm or other weapon in a threatening manner toward the case manager.
2. A written report of a Level II Safety Offense shall result in the following actions:
  - a. The case manager shall contact appropriate authorities, including law enforcement officials or Adult Protective Services staff.
  - b. CM services shall be terminated following timely notice of action to the customer. Loss of CM services shall result in the following:
    - i. Termination of all SCA/OAA services;
    - ii. Option to self-direct SCA services will no longer be available; and
    - iii. Possible termination of services funded by other sources.
  - c. At the time of service termination, a copy of the written report identifying the offense, documentation in the customer's case log, and customer notice of action shall be submitted to the KDADS OAA/SCA Program Manager.

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- H. The customer must show steps have been taken to correct the Level I or Level II offense through counseling, rehabilitation for the behavior, or other appropriate action before CM services may be re-instated.

### 3.1.12 Reasons for Discharge from Case Management Services

- A. The following are reasons for service discharge and numbering correspond to data entry codes in state designated MIS. Reserved codes not available for use included: 1, 8, 12, 16, 22, 24, 26, 27, 28, and 30:
  - 2. Death of Customer;
  - 3. Customer moved out of planning service area, but remains in Kansas;
  - 4. Customer moved to adult living facility with supportive services
  - 5. Customer moved to nursing facility;
  - 6. Customer chose to terminate services, including revoked their release of information or moving out of state;
  - 7. Service is not available to meet customer service need, including critical services for customer's health and welfare needs;
    - a. Customer is determined to be no longer safe in his or her own home; (Note: Data entry code is 7 in State MIS; Notice of Action require designation of why service is not available.
    - b. Customer condition deteriorated and service discontinued; (Note: Data entry code is 7 in State MIS; Notice of Action require designation of why service is not available.
  - 9. Customer failure to pay his or her co-pay (SCA only)
  - 11. Customer no longer meets AAA's OAA or SCA functional criteria;
    - a. Customer condition improved and service is discontinued (Note: Data entry code is 11 in State MIS; Notice of Action allows for discontinue of one service based on improvement and continuance of other services based on customer need and functional criteria).
  - 13. Program or service ended or terminated due to funding change;
  - 14. One time service delivered, such as assessment or installation, includes short term CM services available for one time services.

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15. Service(s) discontinued/not available due to lack of service provider and/or staff.
  20. Customer or family interfere with service delivery to the point that it interferes with the AAA's/CME's or provider's ability to provide services;
  21. Customer transferred to another funding source for the service;
  23. Customer refused to sign or failed to abide by the POC or the customer service worksheet;
  25. Customer whereabouts is unknown;
  32. Customer, family member, or other person present in the household committed a Level I Safety Offense as specified in Section 3.1.11 and did not comply with the action plan to correct the problem; or
    - a. Customer, family member, or other person present in the household committed a Level II Safety Offense as specified in Section 3.1.11. (Note: Data entry code is 32 in State MIS; Notice of Action requirements require designation between Level 1 and Level 2 Safety Offenses)
    - b. The customer refuses to sign the "Customer Code of Conduct" (SS-043). (Note: Data entry code is 32 in State MIS; Notice of Action requires designation of case closure due to no Customer Code of Conduct.



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This section has been revoked.

### **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.

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**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**

<b>Service A</b>	<b>Service B</b>
Home Management of IADLs <ul style="list-style-type: none"> <li>• Shopping</li> <li>• House cleaning</li> <li>• Meal preparation</li> <li>• Laundry</li> </ul>	IADLs <ul style="list-style-type: none"> <li>• Medication setup, cuing and reminding (supervision only)</li> </ul>
	<b>ADLs-attendant supervises the customer</b> <ul style="list-style-type: none"> <li>• Bathing</li> <li>• Grooming</li> <li>• Dressing</li> <li>• Toileting</li> <li>• Transferring</li> <li>• Walking/Mobility</li> <li>• Eating</li> <li>• Accompanying to obtain necessary medical services</li> </ul>

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**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.

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**3.4.1.C (cont.)**

**Level II**

(An initial RN evaluation visit is necessary)

<b>Service C</b>	<b>Service D</b>
ADLs- physical assistance or total support <ul style="list-style-type: none"> <li>• Bathing</li> <li>• Grooming</li> <li>• Dressing</li> <li>• Toileting</li> <li>• Transferring</li> <li>• Walking/Mobility</li> <li>• Eating</li> <li>• Accompanying to obtain necessary medical services</li> </ul>	Health Maintenance Activities <ul style="list-style-type: none"> <li>• Monitoring vital signs</li> <li>• Supervision and/or training of nursing procedures</li> <li>• Ostomy care</li> <li>• Catheter care</li> <li>• Enteral nutrition</li> <li>• Wound care</li> <li>• Range of motion</li> <li>• Reporting changes in functions or condition</li> <li>• Medication administration and assistance</li> </ul>
	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.



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**3.4.1.C (cont.)**

**Level III**

(An initial RN evaluation visit is necessary)

<p>ADLs- Supervision, physical assistance, or total support</p> <ul style="list-style-type: none"> <li>• Bathing</li> <li>• Grooming</li> <li>• Dressing</li> <li>• Toileting</li> <li>• Transferring</li> <li>• Walking/Mobility</li> <li>• Eating</li> <li>• Accompanying to obtain necessary medical services</li> </ul>	<p>Health Maintenance Activities</p> <ul style="list-style-type: none"> <li>• Monitoring vital signs</li> <li>• Supervision and/or training of nursing procedures</li> <li>• Ostomy care</li> <li>• Catheter care</li> <li>• Enteral nutrition</li> <li>• Wound care</li> <li>• Range of motion</li> <li>• Reporting changes in functions or condition</li> <li>• Medication administration and assistance</li> </ul>
<p>IADLs</p> <ul style="list-style-type: none"> <li>• Shopping</li> <li>• House cleaning</li> <li>• Meal preparation</li> <li>• Laundry</li> <li>• Medication setup, cuing and reminding</li> </ul>	<p>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.</p>
	<p>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.</p>

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.

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**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.

<b>IADLs</b>	<b>ADLs</b>
<ul style="list-style-type: none"> <li>• Shopping</li> <li>• House cleaning</li> <li>• Meal preparation</li> <li>• Laundry</li> <li>• Medication setup, cuing or reminding, and treatments</li> </ul>	<ul style="list-style-type: none"> <li>• Bathing</li> <li>• Grooming</li> <li>• Dressing</li> <li>• Toileting</li> <li>• Transferring</li> <li>• Walking/Mobility</li> <li>• Eating</li> <li>• Accompanying to obtain necessary medical services</li> </ul>
<b>HEALTH MAINTENANCE ACTIVITIES</b>	
<ul style="list-style-type: none"> <li>• Monitoring vital signs</li> <li>• Supervision and/or training of nursing procedures</li> <li>• Ostomy care</li> <li>• Catheter care</li> <li>• Enteral nutrition</li> </ul>	<ul style="list-style-type: none"> <li>• Wound care</li> <li>• Range of motion</li> <li>• Reporting changes in functions or condition</li> <li>• Medication administration and assistance</li> </ul>

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(1), 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](http://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)

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#### 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.



**KANSAS DEPARTMENT ON AGING**

**Section 3.4 Home and Community Based Services-Frail Elderly-Services and Rates**

**Effective Date: November 1, 2011**

**Revision: 2011-06**

**3.4.2 HCBS/FE Rates**

<b>Code</b>	<b>Service</b>	<b>Rate</b>	<b>MMIS Billing Code</b>
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

### 3.5 Home and Community Based Services Waiver for the Frail Elderly (HCBS/FE)

#### 3.5.1 Program Description and Purpose

The HCBS/FE waiver provides community based services as an alternative to nursing facility care, to promote independence in the community setting and to ensure residency in the most integrated environment. In Kansas, if customers qualify for nursing facility care, they may choose home and community based services, if available, or enter a nursing facility.

#### 3.5.2 Definitions

**Acting on the Customer's Behalf:** The designation of an individual to act on behalf of the customer allows the customer to delegate responsibility for decisions including, but not limited to, the following:

- appointing the caregiver(s) or attendants(s),
- making financial decisions,
- making health care decisions,
- answering questions during assessments, and
- signing documents.

This delegation is limited to activities necessary to the HCBS case. This designation must also be made either verbally or in writing prior to the start of the initial assessment for HCBS services, or at the time of any subsequent assessments. If this designation is made verbally, it shall be documented in the case log. The customer can change the person authorized to act on their behalf by notifying the Targeted Case Manager (TCM) at any time.

However, if the customer has a court appointed guardian, conservator, an agent appointed by an activated durable power of attorney for health care decisions or durable power of attorney, a representative payee, or federal fiduciary, that appointee shall be the person acting on the customer's behalf subject to any statutory and court ordered limitations.

**Adult Care Home:** Any nursing facility, nursing facility for mental health, intermediate care facility for the mentally retarded, assisted living facility, residential health care facility, home plus, boarding care home, or adult day care facility. All of these classifications of adult care homes are required to be licensed by the Kansas Department on Aging (KDOA).

**Choice Date:** The date the customer has officially chosen HCBS/FE and has signed the Customer Choice form (KDOA-900).

**Customer's Representative:** Any person acting on the customer's behalf, including a court appointed guardian, conservator, an agent appointed by an activated durable power of attorney for health care decisions or durable power of attorney, a representative payee, or federal fiduciary.

**3.5.2 (cont.)**

**Short-term Stay:** (Also known as **planned brief stay** or **temporary stay**) A temporary placement in an institution (nursing facility, hospital or rehabilitation unit). The short-term stay will include the month of admission and the two months following admission.

**Significant Change in Condition:** A change in the customer's status that impacts the scoring of two or more Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and/or Risk Factors including cognition, and which results in a change to the plan of care (POC).

**Working Day:** Any day other than a Saturday, Sunday, or day designated as a holiday by the United States congress or the Kansas legislature or governor.

**3.5.3 General Eligibility Guidelines**

Eligibility is based on the following:

**A. Age**

Customers must be 65 years of age or older.

**B. Customer Choice of HCBS/FE**

1. The customer or customer's representative must choose HCBS/FE, which is indicated on the Customer Choice form.
2. Home and Community Based Services for the Physically Disabled (HCBS/PD) customers who are approaching their 65th birthday shall be given the choice to either continue participation in the HCBS/PD program or transfer to the HCBS/FE program once they turn 65 years of age.
  - a. Customers that choose the HCBS/PD program may transfer to the HCBS/FE program at any time on or after their 65th birthday.
  - b. Customers that choose the HCBS/FE program may not transfer back to the HCBS/PD program at a later point in time.

HCBS/PD customers whose cases have been closed and are later found eligible for HCBS after reaching the age of 65 shall only have the program option of HCBS/FE.

**C. Functional Need**

To be eligible for the HCBS/FE waiver, the customer must meet the **Medicaid Long Term Care Threshold criteria**, based on the results of the Long Term Care (LTC) Threshold Guide of the Uniform Assessment Instrument (UAI) as follows:

**3.5.3.C (cont.)**

1. The customer has impairment in a minimum of two (2) ADLs with a minimum combined weight of six (6); and impairment in a minimum of three (3) IADLs with a minimum combined weight of nine (9); and a total minimum level of care score of 26; or
2. The customer has a total minimum score of 26, with at least 12 of the 26 being IADL points and the remaining 14 being any combination of Cognition, IADL, ADL, and/or Risk Factor points.

**D. Medicaid Eligibility**

Adults residing in Kansas are financially eligible for HCBS/FE if they are:

1. Supplemental Security Income (SSI) customers under Title XVI of the Social Security Act whether or not they are receiving a cash grant; or
2. Customers who have been determined Medicaid eligible.

**E. Available Service Providers**

A customer is eligible for HCBS/FE until such time as service providers or other resources are unavailable to implement all services on the POC. It is the responsibility of the TCM to identify and locate service providers and/or community resources.

**F. Waiver Constraints**

Under the HCBS/FE waiver, the number of individuals served can be limited and the cost-effectiveness must be maintained. The State must ensure that the average per capita Medicaid expenditure under the waiver does not exceed the average per capita Medicaid expenditure that would have been made under the Medicaid State Plan if the waiver had not been granted.

**3.5.4 Procedure for Eligibility Determination and Implementation of Services**

**A. Types of Referrals**

1. A referral from a Kansas Department of Social and Rehabilitation Services (SRS) Medicaid Eligibility Worker and/or Adult Protective Services (APS) worker. The ES-3160 and ES-3161 are the forms designated for communication between the SRS Medicaid Eligibility Worker and TCM.

**3.5.4A(cont)**

2. A verbal or written request from the individual or from a family member or agency acting on his/her behalf. If applicant requests services and has not applied for Medicaid, the individual must be referred to SRS Medicaid staff for eligibility determination, either before or after the functional assessment. The TCM must make contact with the individual, family member, or agency.
3. A request from an individual or Center for Independent Living to transfer from one waiver to another.

**B. Financial Determination**

1. The SRS Medicaid Eligibility Worker:
  - a. makes the determination for financial eligibility for Medicaid payment of community based services funded through Title XIX, Medicaid;
  - b. provides to the TCM written information regarding approval or denial;
  - c. determines the amount of the client obligation (if applicable);
  - d. informs the customer or customer's representative of the customer's client obligation; and
  - e. informs the TCM, in writing, of the amount of the client obligation for the customer.
2. TCMs should assist the SRS Medicaid Eligibility Worker as necessary with collecting information in order to determine eligibility.
3. The TCM and the customer or customer's representative determine to which provider to pay the obligation (Section 3.5.5.F.3).

**C. Functional Determination**

All applicants for HCBS/FE shall be evaluated using the LTC Threshold Guide of the UAI. The customer has the option of receiving community-based services under HCBS/FE waiver if found functionally eligible (see Section 3.5.3.C).

**D. Initial Service Implementation**

1. The TCM shall notify the SRS Medicaid Eligibility Worker of the choice date of HCBS/FE using the ES-3160.
2. The TCM shall then negotiate with the SRS Medicaid Eligibility Worker, customer or customer representative, and providers to determine the start date of HCBS/FE services in conjunction with the completed financial determination.

**3.5.4.D (cont.)**

3. The TCM shall complete the POC and implement service delivery within seven (7) working days from the TCM's completed functional eligibility determination and receipt of the customer's financial eligibility determination from the SRS Medicaid Eligibility Worker. It is the TCM's responsibility to have documentation via the ES-3160 or I006 that ensures the customer has Medicaid financial eligibility and coding that cover the effective dates of the POC(s). Failure to do so will result in the Case Management Entity (CME) paying the provider(s) for services rendered.

**E. Case Management Entity Responsibilities**

1. All HCBS/FE applicants and customers shall be assessed using the UAI. The LTC Threshold Guide is used to calculate the customer's level of care score to determine functional eligibility.
2. Whenever an individual is determined eligible for HCBS/FE services, the TCM must:
  - a. review the Customer Code of Conduct;
  - b. explain the option to self-direct certain services and the rights and responsibilities of this option as indicated on the Financial Management Services (FMS) Statement of Understanding;
  - c. inform the customer or customer representative of the customer's rights and responsibilities regarding HCBS/FE;
  - d. complete a Customer Choice form;
  - e. complete a Targeted Case Management-Frail Elderly (TCM-FE) Provider Choice form;
  - f. discuss currently suspended services and Crisis Exception process with the customer;
  - g. determine the need for waiver services after completing the Customer Service Worksheet (CSW);
  - h. submit an Additional Time Request (ATR) for review, if applicable (appendix I);
  - i. develop a POC with the customer or customer representative, based upon the assessment of the customer's functional needs;
  - j. assist customer with completion of the HCBS/FE Back-up Plan form;
  - k. complete the Physician/RN statement (if applicable) prior to the authorization of medication set-up or health maintenance activities;
    - l. complete the ES-3160;
  - m. complete all necessary documentation to implement the POC;
  - n. send the POC, CSW, and Notice of Action (NOA) to the customer or customer's representative and appropriate providers in accordance with Section 1.3 to authorize the customer's waiver services prior to the implementation of those services; and
  - o. maintain the required original HCBS/FE forms completed for the customer and all other pertinent forms and information received from other sources in the case file.

## KANSAS DEPARTMENT ON AGING

### Section 3.5 Home and Community Based Services for the Frail Elderly

Effective Date: January 01, 2012

Revision: 2012-01

#### 3.5.4E (cont.)

3. After the customer is determined functionally eligible for HCBS/FE services, the customer or customer's representative must:
  - a. sign the Customer Code of Conduct form;
  - b. sign the FMS Statement of Understanding;
  - c. sign the Customer Choice form;
  - d. sign the TCM-FE Provider Choice form;
  - e. assist in the development of the CSW;
  - f. assist in the development of and sign the HCBS/FE Back-up Plan form; and
  - f. return the completed Physician/RN Statement, if applicable, to the appropriate TCM prior to the authorization of medication set-up or health maintenance activities.
4. TCMs shall assess each HCBS/FE customer annually in accordance with Section 2.6. At a minimum, the annual assessment shall include the following:
  - a. a new UAI. The UAI and Kansas Aging Management Information System (KAMIS) POC must be data entered no later than the 15<sup>th</sup> of the following month (see Section 2.6 for the UAI Requirements);
  - b. a new CSW, if necessary;
  - c. a new POC, or if a new POC is not necessary, the existing POC signed and dated by the customer or customer's representative and TCM to indicate that it still applies;
  - d. a new NOA indicating continued eligibility;
  - e. a new ES-3161, which is sent to the SRS Medicaid Eligibility Worker;
  - f. the FMS Statement of Understanding, the Customer Choice form, the TCM-FE Provider Choice form, and the HCBS/FE Back-up Plan form initialed and dated by the customer or customer's representative and the TCM to indicate that they have been reviewed;
  - g. The TCM shall submit an ATR for review if applicable (see Appendix I).
  - h. If there are changes related to customer choices or health maintenance activities, a new Customer Choice form and a new Physician/RN statement are required, if applicable.
5. The KAMIS POC must accurately reflect the paper POC. If services begin on a date other than the first day of the month, the POC must be prorated to reflect that accurate start date.
6. The start date as entered into KAMIS allows providers of HCBS/FE services to be reimbursed effective with this date of service.

The TCM shall not send an NOA to implement a POC until appropriate authorization has been received from KDOA (approved Effective Dating Request, approved Assistive Technology

Request, or approved KAMIS POC). Implementation of the POC without KDOA authorization will result in the CME paying the provider(s) for services rendered.

### **3.5.5 HCBS/FE Plan of Care**

#### **A. Plan of Care (POC) Development**

1. Services provided are based upon the needs of the customer identified through the assessment process as noted on the UAI, CSW, and POC.
2. With the customer or customer representative's approval, family members or other individuals designated by the customer or customer's representative are encouraged to participate, to the greatest extent possible, in the development and implementation of the POC. If the customer has a court appointed guardian/conservator or an activated durable power of attorney (DPOA) for health care decisions, the guardian/conservator or the holder of the activated DPOA for health care decisions must be included and all necessary signatures documented on the POC.
3. When there are other individuals living in the home in which the customer resides, the meal preparation, shopping, and laundry/housekeeping must be provided as an informal support and documented on the CSW and POC. If the individual(s) refuses or is unable to perform any of the above tasks and this is documented in the customer's case file, these services may be provided formally by an individual not residing in the home. Under no circumstances will an individual living in the home be reimbursed for performing these tasks.
4. The TCM and the customer or customer's representative must identify the services that are currently provided through informal supports. These services must continue to be provided informally and documented as such on the CSW and POC. If the individual(s) refuses or is unable to perform any of these tasks and this is documented in the customer's case file, these services may be provided formally by an agency. Upon an agency not being available, these services may be provided by a non-family member (not related by blood or marriage) through the self-direction option.
5. The TCM shall complete appropriate forms indicating service tasks necessary to enable the customer to live safely in the most integrated environment possible. A medical care provider's statement may be required if there is any question about physical disabilities or limitations. If the customer or customer's representative elects to self-direct and requires health maintenance activities or medication set-up paid through Attendant Care Services, a physician/RN statement is required.



**3.5.5.A (cont.)**

6. The TCM must negotiate with providers the rate of services and discuss the hours of care to be delivered to the customer.
7. The TCM shall update and list all services received by the customer on the POC. The TCM shall document all services being provided to a customer including formal and informal services (e.g., provided by volunteers, family, church, neighbors, peers, or other service agency). If Attendant Care II is a provided service, the case is not self-directed, and skilled nursing is currently being provided, skilled nursing must be listed on the paper and KAMIS POCs.
8. For each service change, the POC must be signed or re-signed by both the TCM and the customer or customer's representative. The signature of the customer or customer's representative may be obtained at the home visit or the next home visit.
9. The TCM shall record all pertinent information received verbally or in writing from the customer, customer's representative, staff, or collateral contacts in the case log.
10. The TCM shall obtain the necessary authorization from a POC Approver.
11. The TCM shall send the POC and appropriate NOA and CSW to all involved parties, i.e., customer, customer's representative, and providers.

**B. Development of the Plan of Care for Assisted Living Facilities, Residential Health Care Facilities, and Home Plus**

When a customer or customer's representative chooses HCBS/FE and lives in an Assisted Living Facility, Residential Health Care Facility, or Home Plus, the TCM, in addition to the steps outlined in Section 3.5.5.A, must do the following:

1. encourage the customer or customer's representative to negotiate the room and board costs with the facility staff (the TCM may advocate on behalf of the customer as needed);
2. review the Functional Capacity Screen with the facility staff for consistency with the development of the CSW and POC;
3. review the Negotiated Service Agreement to identify the tasks the facility will provide within the room and board charge, and sign if needed;
4. develop the POC with the customer or customer's representative and the facility staff based on needs identified using the UAI and CSW; and
5. ensure that all required parties have signed the POC after completion.

**3.5.5B (cont.)**

**C. Development of the Plan of Care for Long Term Care (LTC) Insurance and Veterans Benefits**

1. The TCM must complete the CSW and POC based on customer need. The TCM will list all the services/tasks to be provided to the customer on the CSW. Those services/tasks funded by LTC Insurance or Veterans Benefits shall be listed in the informal column.
  - a. Customers in a home setting must negotiate in-home services privately with the provider, based on available LTC Insurance benefits or Veterans Benefits. The customer or customer's representative or the provider must then notify the TCM of what services/tasks are to be funded by LTC or Veterans Benefits so the CSW may be adjusted accordingly.
  - b. Customers residing in an Assisted Living Facility, Residential Health Care Facility, or Home Plus must negotiate the room and board rate based on the customer's income and available LTC Insurance or Veterans Benefits. The customer or customer's representative or the assisted living facility, residential health care facility, or home plus must then notify the TCM of what services/tasks are to be funded by LTC Insurance or Veterans Benefits so the TCM may adjust the CSW accordingly.
2. Medicaid is the payer of last resort and all other available funding must be utilized before services will be provided through HCBS/FE. If there are no tasks left for HCBS/FE to cover after adjusting the services/tasks provided by LTC Insurance or Veterans Benefits in the informal column, the customer's case is closed.

**D. Monitoring, Evaluating and Updating the Plan of Care**

1. TCMs are required to make contact with the customer or customer's representative for monitoring purposes on a quarterly basis, at a minimum, including two face-to-face visits with each customer annually or as otherwise required to meet customer's needs or as related to policy changes.
2. In order to evaluate the POC, the TCM shall do the following:
  - a. determine customer satisfaction with services and providers;
  - b. review the appropriateness of the CSW and POC to ensure the customer's needs are being met;

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#### 3.5.5.D.2 (cont.)

- c. update the UAI, CSW, POC, and LTC Threshold Guide if there have been changes in the customer's health or medical condition, and initial and date all updated forms;
  - d. obtain the customer or customer representative's signature for each update made to the POC during the next home visit;
  - e. prorate the POC if providers or services change on any date except the first of the month; and
  - f. send the CSW, if applicable, POC, and NOA if the POC has changed.
3. Changes in functions, tasks, level of assistance or number of service hours on the customer's CSW require the approval of the TCM. Permanent changes to the frequency of service hours require prior TCM approval. All changes to the POC shall involve the customer or customer representative's participation. The TCM shall send the customer or customer representative and the service provider(s) an NOA indicating any change(s).

When an unexpected change in the customer's social circumstances, mental status or medical condition occurs which would affect the type, amount, or frequency of services being provided during the authorization period, the TCM shall be responsible for making necessary changes in the authorization of services on a timely basis, in accordance with the procedures listed below.

- a. When the change in the customer's service needs results solely from a change in social circumstances including, but not limited to, loss or withdrawal of support provided by informal caregivers, the TCM shall review the social assessment, document the social circumstance, and make changes in the CSW if needed.
- b. When the change in the customer's service needs results from a change in mental status including, but not limited to, loss of ability to make judgments, the TCM shall review the Health and Cognition modules of the UAI, document the changes in the customer's mental status, and take appropriate action as needed.
- c. When the change in the customer's service needs results from a change in medical condition, the TCM shall update the current or complete new HCBS/FE forms, obtain a new Physician/RN Statement for customers who choose to self-direct their care, if needed, and complete a new assessment if a significant change in condition has occurred.

3.5.5.D.3 (cont.)

- d. When the change in the customer's service needs results from a change in the customer's environment including, but not limited to, a change in customer's residence, the TCM shall update the assessment, document the change in the customer's status, and take appropriate actions.
4. The TCM shall review the Customer's Rights and Responsibilities with the customer or customer's representative at least annually or whenever there is an adverse action affecting the customer's POC.

**E. Effective Dates of Plans of Care**

As stated in Section 3.5.4.E.7, the TCM shall not implement a POC until a POC Approver has authorized the POC. The effective date of a POC must be after the date and time the POC Approver has authorized it. Under no circumstances may the effective date of the POC precede the date the customer or customer's representative chooses HCBS/FE. If the customer has needs over the maximum time limits, Effective Dating Requests may only be submitted after KDOA approval for additional time is received.

Before a POC will be approved for effective dating, the TCM shall submit the request to the Effective Dating Request web application for consideration. **(Note: The Medicaid eligibility date will supersede the effective date if the two are different.)**

1. A customer may qualify for an effective date of service that is prior to the POC approval date if a customer has already been deemed financially and functionally eligible for Medicaid, will be receiving HCBS/FE services from an HCBS/FE enrolled provider, and meets any one of the following criteria:
  - a. If a customer is going to be discharged from a hospital or nursing facility AND needs services to begin immediately as determined by the TCM, and prior to the discharge the TCM has notified the POC Approver of the need for services and level of care, then the POC may be implemented upon discharge as approved by KDOA.

The CME must enter the POC into KAMIS within three (3) working days of the customer's discharge from the hospital or nursing facility.

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**3.5.5.E.1 ( cont.)**

- b. If the SRS Medicaid Eligibility Worker is unable to modify the KAECSES/MMIS coding due to computer related problems, then the TCM shall immediately notify the POC Approver of the problem. The POC Approver may authorize the POC with an effective date of service delivery that is equivalent to the date that KDOA was notified and approval was given.

The CME must ensure that the POC is entered into KAMIS within three (3) working days of when the SRS Medicaid Eligibility Worker modifies the code

- c. If a customer currently resides in an HCBS/FE enrolled Assisted Living Facility, Residential Health Care Facility, Boarding Care Home, Home Plus, or non-medical Resident Care Facility and has signed a Customer Choice form, the TCM shall notify the POC Approver of the need to begin, add, or increase services immediately. The POC Approver may authorize the POC with an effective date of service delivery that is equivalent to the date KDOA is notified.

The CME must enter the POC into KAMIS within three (3) working days of the approval date.

- d. If a customer moves into an HCBS/FE enrolled Assisted Living Facility, Residential Health Care Facility, Boarding Care Home, Home Plus, or a non-medical Resident Care Facility on a weekend or a holiday, the POC approver may authorize the POC equivalent to the move-in date, if the TCM notifies KDOA by close of business of the next working day.

The CME must enter the POC into KAMIS within three (3) working days of the approval date.

- e. If a customer or customer's representative has a signed choice form, the TCM has authorized services that were provided and an error has occurred, and this documentation is sent to the POC Approver, then the change to the effective date of the POC may be approved by the TCM Program Manager.

The CME must enter the POC into KAMIS within three (3) working days of the approval date.

**3.5.5.E (cont.)**

2. KDOA may revoke an approved effective dating request if other program requirements are not met, including the following:
  - a. the time frame for KAMIS POC data entry is not followed;
  - b. the customer does not have TXIX or HC/FE coding effective for the date approved; or
  - c. the provider is not an enrolled HCBS/FE provider.

**F. Client Obligation**

1. The client obligation will be recorded on the POC initially and with each obligation change. Using the criteria below, the TCM and the customer or customer's representative will identify to which service provider the client obligation will be applied.
  - a. Whenever possible, the entire client obligation should be applied to a single service provider.
  - b. To the greatest extent possible, the customer's primary service will be used to meet the client obligation. If this service does not fully meet the client obligation, then another waiver service may be used in conjunction with the primary service to meet the client obligation.
2. Only the SRS Medicaid Eligibility Worker can adjust the monthly client obligation amount. If the SRS Medicaid Eligibility Worker makes any changes to the monthly client obligation, it is their responsibility to notify the TCM in writing.
3. Using an NOA, the TCM shall notify the customer or customer's representative to which service provider the client obligation will be paid.
4. The TCM shall notify the service providers, in writing, using the same NOA used in paragraph 3 above, of any client obligation or adjusted obligation that is to be applied toward their service. The service providers are responsible for collecting the client obligation directly from the customer.
5. Client Obligations cannot be prorated on the POC.
6. The KAMIS POC must accurately reflect the amount of the client obligation as identified on the EDS inquiry screen and must accurately document to which provider the obligation is applied.

**3.5.5.F (cont.)**

7. The TCM shall report the cost of the POC, excluding Acute Care Costs, to the SRS Medicaid Eligibility Worker to ensure that the cost is enough to cover the client obligation.
8. If the client obligation exceeds the cost of the pro-rated POC, excluding Acute Care Costs, for the first month of service, the HCBS case can be opened.
9. The TCM shall not open an HCBS/FE case if the client obligation exceeds the cost of the POC, excluding Acute Care Costs, on an ongoing basis.

**3.5.6 Cost Cap Amount**

The monthly cost cap amounts for HCBS/FE services are as follows:

- Level I is \$1,965;
- Level II is between \$1,965.01 and \$3,999.99;
- Level III is \$4,000.00 and over.

**3.5.7 Interruption of Services**

HCBS/FE services, with the exception of Personal Emergency Response and Medication Reminder, shall be suspended during a short-term stay (planned brief stay or temporary stay) using an NOA. If the end date is not known at the time of the initial NOA, a second NOA must be sent to reinstate services. The HCBS/FE case shall remain open for case management services and payment of Personal Emergency Response, Medication Reminder, and Financial Management Services for a period no longer than two calendar months following the month in which services were suspended (e.g. if a short-term stay began on July 3<sup>rd</sup>, the case could remain open until September 30<sup>th</sup>). **Prorating the KAMIS POC is not required in this situation.**

**3.5.8 Supplementation of HCBS Services (KAR 30-5-308)**

- A. An organization, agency, family, customer, or other individual shall not be allowed to pay for services that are on the POC.
- B. A customer may accept the following:
  - 1. any available service that is provided free and voluntarily by one or more organizations, agencies, families, or other individuals, at no cost to the Medicaid program; and
  - 1. any available, desired services in addition to those services on the POC that are purchased by the customer or one or more organizations, agencies, families, or other individuals, at no cost to the Medicaid program.

**3.5.9 Self-Directed Care Requirements**

There are numerous functions of the Self-Directed Care Services Option that must be performed by the Financial Management Services (FMS) provider and the customer or customer's representative.

**A. Customer Responsibilities**

The customer or customer's representative is responsible for the activities listed below:

- 1. Act as the employer for the direct support worker(s) (DSW) or designate a representative to manage or help manage the DSW(s).
- 2. Negotiate an FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the customer and the FMS provider.
- 3. Select the DSW(s).
- 4. Refer the DSW(s) to the FMS provider for completion of required human resources and payroll documentation. (Note: In cooperation with the FMS provider, all employment verification and payroll forms must be completed.)
- 5. Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties.
- 6. Provide or arrange for appropriate orientation and training of the DSW(s).
- 7. Determine the schedules of the DSW(s).



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**3.5.9.A (cont.)**

8. Determine the tasks to be performed by the DSW(s) and where and when they are to be performed, in accordance with the approved and authorized POC/CSW and/or others as identified and/or are appropriate.
9. Manage and supervise the day-to-day HCBS activities of the DSW(s).
10. Verify the time worked by the DSW(s) was delivered according to the POC and approve and sign the time sheets.
11. Ensure the DSW's time sheets and all other required documents are submitted to the FMS provider for processing and payment in accordance with the established FMS, state, and federal requirements. (Note: The time sheet must reflect actual hours worked in accordance with an approved POC.)
12. Report work-related injuries incurred by the DSW(s) to the FMS provider agency staff.
13. Develop an emergency worker backup plan in case a substitute DSW is ever needed on short notice or as a backup (short-term replacement worker).
14. Ensure all appropriate service documentation is recorded as required by the State of Kansas HCBS waiver program policies and procedures, or by the Medicaid Provider Agreement.
15. Inform the FMS provider of any changes in the status of DSW(s), such as a change of address or telephone number, in a timely fashion.
16. Inform the FMS provider and targeted case manager of the dismissal of a DSW within three working days.
17. Inform the FMS provider and targeted case manager of any changes in the status of the customer or customer's representative, such as the customer's address, telephone number, or hospitalizations, within three working days.
18. Participate in required quality assurance visits with TCMs, state Quality Assurance staff, state Quality Management Specialist (QMS), or other appropriate and authorized reviewers/auditors.

**3.5.9 (cont.)**

**B. FMS Provider Responsibilities:**

The FMS provider is responsible for the activities listed below:

1. Comply with the provisions of KSA 39-7,100 (Home and community based services program) and KSA 65-6201 (Individuals in need of in-home care; definitions).
2. Execute a Kansas Department of Social and Rehabilitation Services (SRS)/Kansas Department on Aging (KDOA) Provider Agreement with the appropriate state agency.
3. Execute a Medicaid Provider Agreement with Kansas Health Policy Authority (KHPA).
4. Comply with state regulations, SRS/KDOA Provider Agreement requirements, Medicaid Provider Agreement requirements, policies, and procedures to provide services to eligible customers.
5. Develop and implement procedures, internal controls, and other safeguards that reflect Kansas state law (the guiding principles of self-direction) to ensure the customer or customer's representative, rather than the FMS provider, have the right to choose, direct, and control the services and DSW(s) who provide them without excessive restrictions or barriers. The procedures, internal controls, and other safeguards must be written and must include, at a minimum:
  - a. A mechanism to process the DSW's human resource documentation and payroll in a manner that is efficient and supports the customer's or customer's representative's authority to select, recruit, hire, manage, dismiss, and train DSWs;
  - b. Information for the DSW that outlines the completion of time sheets, wages, benefits, pay days, work hours, and the customer's self-direct preferences;
  - c. An assurance that the customer or customer's representative, not the FMS provider, determines the terms and conditions of work, to include the following:
    - i. when and how the services are provided, including establishing work schedules;
    - ii. determining work conditions (for example, smoking restrictions in the home, conditions for dismissal); and
    - iii. tasks to be performed.

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**3.5.9.B (cont.)**

- d. Internal controls to ensure the customer or customer's representative is afforded choice and control over workers without excessive restrictions or barriers;
  - e. A process to respond, within a reasonable time frame, to contact from the customer or customer's representative informing the FMS provider of the decision to dismiss a particular DSW; and
  - f. A process for the self-directing customer or customer's representative to pay the DSW(s) or for the self-directing customer or customer's representative to delegate the DSW(s) payment by direct deposit, first class mailing, or other means through the FMS provider agency staff.
6. Ensure the self-directing customer or customer's representative and the targeted case manager have the name and contact information of the FMS provider agency staff who can address their issues.
7. Assume responsibilities in providing the following administrative services:
- a. Establish and maintain all required records and documentation, to include a file for each self-directing customer per State of Kansas regulations, policies, and procedures and in accordance with Medicaid provider requirements. (Note: All files must be maintained in a confidential, HIPAA-compliant manner);
  - b. Obtain authorizations to conduct criminal background checks, child abuse, and adult registry checks in accordance with applicable waiver requirements;
  - c. Verify citizenship and legal status of potential DSW(s);
  - d. Collect and process all required federal, state, and local human resource forms required for employment and the production of payroll;
  - e. Help the self-directing customer or the customer's representative set the correct pay rate for each DSW as allowed under the procedures set by the State of Kansas;
  - f. Collect and process the time sheets of the DSW(s);
  - g. Compute, withhold, file, and deposit federal, state, and local employment taxes for the DSW(s);
  - h. Compute and pay workers compensation as contractually and statutorily required;

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**3.5.9.B (cont.)**

- i. Approve and pay wages to the DSW(s) in compliance with federal and state labor laws;
  - j. Perform all end-of-year federal, state, and local wage and tax filing requirements, as applicable (that is, IRS forms W-2 and W-3, state income tax forms, and reporting); and
  - k. Have policies and procedures in place for reporting fraud and/or abuse, neglect, or exploitation by a DSW to the appropriate authority and informing the customer or customer's representative that if the DSW continues to work for the customer, they will no longer be able to serve as the FMS provider agency.
8. Ensure each self-directing customer:
- a. Maintains control and oversight of his or her DSW;
  - b. Is aware of the benefits/services available to him or her;
  - c. Is aware of his or her requirements and responsibilities to the FMS provider agency; and
  - d. Is aware of his or her requirements and responsibilities to the DSW, including a signed Employment Service Agreement that specifies the responsibilities of the parties in a language/format that is understandable to the DSW.
9. Ensure each DSW hired by the self-directing customer:
- a. Is aware of the benefits/services available to him or her; and
  - b. Is aware of the employment requirements and job responsibilities of the self-directing customer and FMS provider.
10. Maintain a listing of DSWs who are available and desire additional employment.
11. Develop, implement, and maintain an internal quality assurance program that monitors for the following:
- a. Self-directed customer's satisfaction;
  - b. DSW's satisfaction;
  - c. Correct time sheet submission; and
  - d. Correct payroll distribution.

**3.5.9.B (cont.)**

12. Develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency.
13. Maintain evidence of certifications, agreements, and affiliations as required by waiver or policy (such as community developmental disability organization [CDDO] affiliation agreements for developmental disabilities services).

**C. Termination of the Self-Directed Care Option**

1. The following situations warrant termination of the self-directed care option if it is documented that the TCM has attempted to remedy the situation and has involved the customer's FMS provider, as needed:
  - a. the customer does not fulfill the responsibilities and functions as outlined in Section 3.5.9;
  - b. the health and welfare needs of the customer are not met as observed by the TCM or confirmed by SRS APS;
  - c. the direct support worker has not adequately performed the necessary tasks and procedures. For Attendant Care Services, this would include not following the CSW; or
  - d. the customer or customer's representative or the direct support worker has abused or misused the self-directed care option, such as, but not limited to the following:
    - i. the customer or customer's representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the CSW and/or POC;
    - ii. the customer or customer's representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the health maintenance activities training was provided to the direct support worker in a manner that will have an adverse effect on the health and welfare of the customer;
    - iii. the customer or customer's representative has directed the direct support worker to provide, and the direct support worker has in fact provided, tasks and procedures beyond the scope of their authorized services; or
    - iv. the customer or customer's representative has submitted signed time sheets for services beyond the scope of the CSW and/or the POC.

**3.5.9.C (cont.)**

2. The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:
  - a. the customer or customer's representative has falsified records that result in claims for services not rendered; or
  - b. the customer or customer's representative has committed a fraudulent act.
3. If the medical care provider or registered nurse no longer authorizes the customer to self-direct health maintenance activities or medication set-up, then the customer no longer has the option to self-direct these activities. The customer may continue to self-direct tasks that are not health maintenance activities or medication set-up. Health maintenance activities and medication set-up must be provided through other means, such as provider directed attendant care, informal supports, or skilled nursing.
4. A timely NOA shall be sent to the customer or customer's representative prior to the effective date for termination of the customer's participation in the Self-Directed Care Option (see Section 1.3 for a definition of Timely NOA).

**3.5.10 Transition from Other Waivers to HCBS/FE Waiver**

The following process shall be followed for customers on other waivers who choose to transfer to the HCBS/FE waiver.

**A. HCBS/Physically Disabled (PD)**

1. Prior to the transfer from the HCBS/PD waiver to the HCBS/FE waiver, the TCM shall complete all required HCBS/FE forms. The PD Case Manager shall coordinate the transfer of any information or documents the TCM would find beneficial.
2. The TCM and the PD case manager shall coordinate the date of transition from the HCBS/PD to the HCBS/FE waiver.
  - a. The PD Case Manager will notify the customer's SRS Medicaid Eligibility Worker of the transfer.
  - b. The PD Case Manager will close out the HCBS/PD waiver prior authorization on MMIS with approval before the HCBS/FE POC can be approved.
  - c. The TCM shall communicate the start date and the new POC costs to the SRS Medicaid Eligibility Worker before the effective date of the transfer.

**3.5.10.A (cont.)**

- d. The SRS Medicaid Eligibility Worker will change the living arrangement and level of care code (LOTC) using the new waiver effective date and complete the ES-3160 and return it to the CME.
- e. The TCM shall send the NOA, POC, and if applicable, the CSW to initiate HCBS/FE services.

**B. HCBS/Traumatic Brain Injury (TBI)**

An HCBS/FE case cannot be opened for a customer who qualifies for services under the HCBS/TBI waiver.

**C. HCBS/Mental Retardation-Developmental Disability (MR-DD)**

An HCBS/FE case cannot be opened for a customer who qualifies for services under the HCBS/MR-DD waiver.

**3.5.11 Communication with the SRS Medicaid Eligibility Worker**

- A. The ES-3160/I006 are forms used to transmit eligibility information. The form may be initiated by the TCM or the SRS Medicaid Eligibility Worker.
- B. The ES-3161/I007 are forms used to transmit information on changes and updates regarding a customer's eligibility status. The form may be initiated by the TCM or SRS Medicaid Eligibility Worker.

**3.5.12 Case Log and Documentation Requirements**

- A. Each case opened and maintained by the CME shall contain a chronological log of case activities recorded in brief, legible statements that document:
  - 1. the date of the initial referral and assessment;
  - 2. monitoring visits, as well as contacts, phone calls, home visits, provider contact and reasons for contact;
  - 3. pertinent facts that include descriptive non-judgmental language;
  - 4. letters and NOA with date sent and copies noted;
  - 5. changes of TCM or providers;

**3.5.12.A (cont.)**

6. client obligation issues or changes in obligation, when applicable;
  7. customer evaluation and monitoring to assure services are provided according to the POC;
  8. changes in the POC and formal or informal support systems, with the customer or customer representative's approval noted;
  9. review of Customer Choice, TCM-FE Provider Choice, Rights and Responsibilities, and satisfaction on an annual basis (or more frequently as needed);
  10. received and sent ES-3160/I006s and ES-3161/I007s;
  11. absences from the home;
  12. ongoing assessments of medical conditions;
  13. all referrals made and to whom; and
  14. contact with the customer or customer's representative and/or service providers.
- B. All progress notes must include the documented time spent on the activity.
- C. The TCM must initial each case log entry and must sign each page of the case log.
- D. Maintain the original HCBS/FE forms completed for the customer and all other pertinent forms and information received from other sources in the case file.

**3.5.13 Transfer of a Customer's Case or KAMIS Person Administration**

When a customer's HCBS/FE case or KAMIS Person Administration is transferred from one CME to another, TCM's are responsible for performing certain duties to ensure a smooth transition. This transfer includes cases closed within the previous six months of the date of request for transfer.

**A. Transfer of HCBS/FE Case Due to Customer Relocation**

1. Sending Case Management Entity Responsibilities

Upon notification of the customer's intent to relocate, the sending CME shall be responsible for the following activities:



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- a. Inform the customer or customer's representative of the available TCM-FE providers;
- b. obtain the customer or customer representative's signature on the TCM-FE Provider Choice form and a release of information for the transfer of records;
- c. contact the CME chosen by the customer or customer's representative to notify them of the upcoming transfer before the transfer occurs;
- d. coordinate the transfer with the receiving CME prior to the customer's relocation, including informing the receiving CME, in writing, of any open/active APS issues or investigations with a description of what the issues are and, if applicable, the name and contact information of the customer's representative, including any designation as the customer's activated DPOA for health care or legal guardianship;
- e. transfer a copy of the following current documents within five (5) working days prior to the start date for the receiving agency:
  - i. POC;
  - ii. UAI;
  - iii. CSW;
  - iv. Signed Customer Choice form;
  - v. Signed Customer Code of Conduct form;
  - vi. Signed TCM-FE Provider Choice form;
  - vii. Signed FMS Statement of Understanding
  - viii. HCBS/FE Back-up Plan form;
  - ix. Corrective Action Plans, if applicable;
  - x. Customer case logs for the preceding six months; and
  - xi. Customer NOAs for the preceding six months.
- f. document the transfer in the customer's file, noting where records were transferred and the date of transfer;
- g. end date all HCBS lines with the exception of the Acute Care Costs (ACC) line on the KAMIS POC as agreed to between case management entities and per KAMIS policy. The POC and UAI must be referred to the receiving CME after the POC has been approved;
- h. release the customer's records in KAMIS to the receiving CME within five (5) working days of receipt of the request for transfer of records. If there is not an existing HCBS/FE POC but the individual has been established in KAMIS, the CME must complete this step;

**3.5.13.A (cont.)**

- i. send an ES-3161 to the SRS Medicaid Eligibility Worker to inform them of the customer's relocation; and
  - j. send an NOA to the customer or customer's representative and the providers to inform them of the customer's relocation.
2. Receiving Case Management Entity Responsibilities:

Upon notification of the customer's request to relocate, the receiving CME shall be responsible for the following activities:

- a. Coordinate the transfer with the sending CME prior to the customer's relocation;
- b. request, per KAMIS, the right to access the customer's POC and UAI;
- c. note the date of receipt of the customer's documents in the case record;
- d. review all HCBS/FE waiver forms with the customer or customer's representative and update as needed;
- e. conduct reassessment if the assessment is past due or there has been a significant change;
- f. enter HCBS-FE service lines on the KAMIS POC;
- g. send an ES-3161 to the SRS Medicaid Eligibility Worker to inform them of the customer's relocation; and
- h. send an NOA, POC, and if applicable, the CSW to the customer or customer's representative and providers to inform them of the current authorized services and of the new case manager.

**3.5.13 (cont.)**

**B. Transfer of HCBS/FE Case Due to Customer Choice**

The customer or customer's representative shall notify their chosen CME of the decision to have his or her case transferred to them for TCM-FE services. Should the customer or customer's representative contact the current CME with this request, the customer or customer's representative shall be instructed to contact the receiving CME to initiate the transfer.

**1. Receiving Case Management Entity Responsibilities:**

Upon notification of the customer or customer representative's request to change case management entities, the receiving CME shall be responsible for the following activities:

- a. Obtain the customer or customer representative's signature on the TCM-FE Provider Choice form and a release of information for transfer of the customer's records;
  - b. fax or e-mail the signed TCM-FE Provider Choice form and the release of information to the current CME to the attention of both the Director and Supervisor;
  - c. request, per KAMIS, the right to access the customer's POC and UAI;
  - d. upon receipt of the customer's case file and access to the customer's records in KAMIS, send an NOA to the customer or customer's representative, the sending CME, and the providers to confirm the change in CME;
  - e. enter HCBS service lines on the KAMIS POC, to begin the first day of the month following the transfer. Pend the POC to KDOA for approval; and
  - f. send an ES-3161 to the SRS Medicaid Eligibility Worker to notify them of the TCM-FE provider change.
2. Upon receipt of a request to release records for the customer's transfer to another CME, the sending CME shall not contact the customer or customer's representative by phone or in person regarding TCM-FE provider choice, unless the customer or customer's representative initiates the contact. However, a written letter or survey may be sent to the customer or customer's representative to request feedback.

**3.5.13.B (cont.)**

3. Sending Case Management Entity Responsibilities:

Upon notification of the customer or customer representative's request to change case management entities, the sending CME shall be responsible for the following activities:

- a. Notify the receiving CME, in writing, of any open/active APS issues or investigations with a description of what the issues are and, if applicable, the name and contact information of the customer's representative, including any designation as the customer's activated DPOA for health care or legal guardianship.
- b. Fax, e-mail, or send via other agreed upon arrangements to the receiving CME the following current documents within five (5) working days of receipt of the release of information for the transfer of records and the signed TCM-FE Provider Choice form:
  - i. POC;
  - ii. UAI;
  - iii. CSW;
  - iv. Signed Customer Choice form;
  - v. Signed Customer Code of Conduct form;
  - vi. Signed FMS Statement of Understanding
  - vii. HCBS/FE Back-up Plan form;
  - viii. Corrective Action Plans, if applicable;
  - ix. Customer case logs for the preceding six months; and
  - x. Customer NOAs for the preceding six months.
- c. End date all HCBS lines with the exception of the ACC line on the KAMIS POC effective the last day of the month the transfer was completed in accordance with KAMIS policy. The POC and UAI must be referred to the receiving CME after the POC has been approved. In the event a CCE Request is in process, the KAMIS records will be transferred within five (5) working days of approval or denial of the KAMIS POC.
- d. Release the customer's records in KAMIS to the receiving CME within five (5) working days of receipt of the request for transfer of records. If there is not an existing HCBS/FE POC but the individual has been established in KAMIS, the CME must complete this step.

**3.5.13 (cont.)**

**C. Failure to Comply**

If a CME fails to timely perform any requirement or provision of Section 3.5.13, time being of the essence, KDOA may take any action or seek any remedy authorized by law including, but not limited to, the referral of such breach to the Kansas Health Policy Authority, which may initiate action to terminate the CME's Medicaid Provider Agreement.

**3.5.14 Case Closure for HCBS/FE**

A. The reasons for case closure for HCBS/FE include the circumstances listed below.

1. Loss of Medicaid financial eligibility.
2. Customer no longer meets HCBS/FE functional eligibility criteria.
3. Lack of cooperation to the point that the customer and/or family substantially interfere with the provider's or the CMEs ability to provide services, (e.g., refusing providers, inability to get along with providers, or inappropriate customer and/or family behaviors). Other options must be explored prior to termination of services.
4. Change in medical condition where health and welfare needs cannot be met with HCBS/FE waiver services.
5. Customer fails or refuses to pay the monthly client obligation as per agreement and the provider is unwilling to continue services and no other provider can be found.
6. Customer or customer's representative fails or refuses to sign or abide by the POC or the CSW.
7. Providers of HCBS/FE services are no longer available or the customer refuses service(s) on the POC.
8. Customer is determined to be no longer safe in his or her own home.
9. Customer or customer's representative chose to terminate services, including moving out of state.
10. Customer is a PACE participant.
11. Customer's whereabouts are unknown (e.g., post office returns mail to the agency indicating no forwarding address).
12. Customer enters a nursing facility and is not expected to return to the community.

**3.5.14.A (cont.)**

13. Customer dies.
  14. Customer or customer's representative refuses to sign the "Customer Code of Conduct" (SS-043).
  15. Customer, family member, or other person present in the household committed a Level I Safety Offense as specified in Section 3.1.11 and did not comply with the action plan to correct the problem.
  16. Customer, family member, or other person present in the household committed a Level II Safety Offense as specified in Section 3.1.11.
- B. The TCM shall complete all case closures with the appropriate documentation and send the SRS Medicaid Eligibility Worker the ES-3161 as needed. The TCM shall send a copy of the case closure notice to all providers listed on the POC. The last date of provider payments will be noted on the NOA and will correspond with KAMIS. The CME must data enter the KAMIS POC closure within ten (10) working days of notification of the customer's death, permanent nursing facility placement, or other closure reason.

**3.5.15 Closing an HCBS/FE File**

The final NOA will substantiate closure to the case and be included in closing the file. The file may be closed after the time to appeal the final NOA passes.

- A. The CME shall retain files for seven (7) years after the file is closed. All HCBS/FE records are kept seven years unless an audit of the case is in process or unless any audit findings, litigation or claims involving the records have not been resolved, in which case, the records shall be maintained until the issue is resolved.
- B. The CME shall retain the complete file, including the documentation required by 42 Code of Federal Regulations (CFR) 431.17(b): (1)(i) to (vi) and (2), as follows:
  1. Individual records on each applicant and recipient that contains information on:
    - a. Date of application;
    - b. Date of and basis for disposition;
    - c. Facts essential to determination of initial and continuing eligibility;
    - d. Provision of medical assistance;
    - e. Basis for discontinuing assistance;
    - f. The disposition of income and eligibility verification information received under 42 CFR 435.940 through 435.960 of this subchapter; and

**3.5.15.B (cont.)**

2. Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

**3.5.16 HCBS/FE Quality Review Process**

As a condition of waiver approval, State Medicaid Agencies are required to meet certain assurances. KDOA, in cooperation with Kansas Health Policy Authority, the state Medicaid agency, participate in several quality assurance initiatives for the purpose of enhancing the quality, effectiveness, and appropriateness of HCBS/FE services and

improving access to and cost-effectiveness of the waiver program. KAMIS POC Authorization and the Quality Review (QR) process, performed by KDOA staff, are pieces of this overall quality management program.

The QR process is designed to give continuous feedback to the KDOA and to each of the CMEs, on a quarterly basis, as to the quality of work being performed. A representative random sample of customer case files are read by each quality reviewer each month. No CME will have its customers reviewed more than once annually unless a second review of a specific case is requested.

- A. The purpose of the review shall include the following:
  1. enhance the quality and effectiveness of HCBS/FE for customers;
  2. ensure customers are offered choice;
  3. improve access to and cost-effectiveness of the waiver program;
  4. ensure quality and accuracy of customer case files that documents customer eligibility, involvement, and needs being met;
  5. determine customer satisfaction with quality of service;
  6. ensure accurate notification to customers of changes to their POC and their Rights and Responsibilities; and
  7. determine accuracy of provider claims.
- B. The reviewer(s) will do the following:
  1. review the case file against an established protocol for customer eligibility, informed choice, and consistency of waiver forms;
  2. interview the customer and/or family member in their home environment to determine if:

**KANSAS DEPARTMENT ON AGING**

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**Section 3.5 Home and Community Based Services for the Frail Elderly**

**Effective Date: January 01, 2012**

**Revision: 2012-01**

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**3.5.16.B (cont.)**

- a. the customer is satisfied with quality of care,
  - b. actual services have been delivered compared to the POC,
  - c. information contained in the case file is accurate, and
  - d. health and welfare needs of the customer are being met;
3. compare Medicaid paid claims against the authorized POC; and
  4. complete the QR forms to be shared with the CME as requested.
- C. File documents that may be copied during the review include the following:
1. LTC Threshold Guide, if it is not in KAMIS;
  2. case logs for TCM documentation review;
  3. paper POC; and
  4. NOAs for provider reviews.
- D. Whenever a quality reviewer encounters an HCBS/FE customer with an identifiable health and/or welfare issue, he or she shall do the following:
1. make a referral to SRS APS or KDOA's complaint hotline if, in the reviewer's and his or her supervisor's opinion, the issue involves abuse, neglect or exploitation of the customer;
  2. report concerns to the TCM supervisor or contact person at the CME if the situation is of concern but does not warrant, in the reviewer's opinion, an APS referral; and
  3. complete a Referral and Response form and mail it to the TCM Supervisor advising of the customer's situation and the issue.
- E. An exit conference will be available for each CME to review the QR forms with the TCMs. The purposes of the exit conference include the following:
1. ensure QR staff did not overlook or misinterpret existing documentation;
  2. discuss any issues regarding the application of the existing protocol; and
  3. discuss any unresolved critical issues.



**3.5.16 (cont.)**

- F. The QR and Performance Measure data will be compiled by KDOA Program Evaluation Unit (PEU) staff. The PEU staff and Program Managers will review the data for the 100% standard expected by CMS. Any findings will require remediation between KDOA and the CME. The remediation process may include one or more of the following actions:
1. KDOA Program Managers will contact CME to inform them of identified finding(s) and determine potential remedies;
  2. CME will provide KDOA, within six (6) working days, a written explanation of the reason, acceptable remedy, and timeframe to resolve the noncompliance;
  3. If an acceptable response is not received from the CME, KDOA Program Manager will send written notification to the CME Director and Supervisor;
  4. If acceptable action is not taken and noncompliance continues, the following actions may be taken:
    - a. KDOA staff will provide additional training to CME staff;
    - b. CME will develop and submit, within 30 days of KDOA's notification, a Corrective Action Plan that is acceptable to KDOA;
    - c. Monetary penalties will be assessed for habitual noncompliance; or
    - d. Suspension or termination of the CME's Medicaid provider agreement.

## **Appendix A: HCBS/FE Forms**

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Assistive Technology Home Modification Proposal (SS-030)  
Back-Up Plan (SS-050)  
Corrective Action Plan (SS-046)  
Crisis Exception Criteria Checklist (SS-049)  
Customer Choice Form\* (KDOA 900)  
Customer Code of Conduct\* (SS-043)  
Customer Rights and Responsibilities\* (SS-012)  
Customer Service Worksheet (SS-009)  
Customer Service Worksheet Supplement (SS-016)  
Expedited Service Delivery Agreement (SS-039)  
Financial Management Services (FMS) Statement of Understanding (SS-052)  
Health and Welfare/Need for Care Physician Statement (KDOA 908) - Optional Form  
Notice of Action (KDOA 904)  
Notification of HCBS: Referral/Initial Eligibility/ Assessment/ Services Information (ES-3160, I006)  
Notification of Medicaid/HCBS: Changes/Updates (ES-3161, I007)  
Physician/RN Statement (KDOA 905)  
Plan of Care/Support Services (SS-005)  
Standard Intake and Information (SS-002)  
Targeted Case Management (TCM)-FE Provider Choice Form\* (SS-045)  
Uniform Assessment Instrument (SS-005)  
Waiting List Notification of Customer Closure (SS-019)

\* Documents marked with an asterisk are available in English, Russian, Spanish, and Vietnamese

These forms are available in Word and pdf format on KDOA's Provider Resource website at:

[http://www.aging.ks.gov/Forms/TCM\\_Forms.html](http://www.aging.ks.gov/Forms/TCM_Forms.html)

## **Appendix B: Process for Billing HCBS/FE Assessments**

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Effective April 1, 2008

Assessment and Plan of Care Development are now billable components of Targeted Case Management (TCM) for customers who are, or become, Medicaid (TXIX) eligible.

With the changes to the components of TCM, the case documentation logs must be updated to reflect the four TCM components.

### **Medicaid eligible at the time of the assessment and reassessment:**

- When the customer is Medicaid (TXIX) eligible at the time the assessment is completed the units spent making contact and conducting the assessment will be identified as Targeted Case Management and billed as T1017 via the MMIS. The assessment is not entered onto the KAMIS POC.

### **Medicaid pending at the time of the assessment or application submitted to SRS after the assessment:**

The CME will need to wait for Medicaid determination prior to submitting claims for payment.

- Upon the customer becoming Medicaid (TXIX) eligible the units spent making contact and conducting the assessment and POC development will be identified as Targeted Case Management and billed as T1017 via the MMIS. The assessment is not entered onto the KAMIS POC.

**OR**

- Upon the customer being denied Medicaid (TXIX) eligibility the units spent making contact and conducting the assessment and POC development will be identified as TCM SGF.
  - The assessment information will be entered onto the KAMIS POC as follows:
    - Service = ASMT
    - Funding = TCM SGF
    - Provider = the CME
    - Units = Units spent on Assessment / POC development
    - Per = Year
    - Units Monthly = Units spent on Assessment / POC development
    - Start date = Start date
    - End date = End date
    - Monthly cost = Cost

## Appendix B: Process for Billing HCBS/FE Assessments

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- After the ASMT information is entered onto KAMIS the units provided will be billed to KDOA as TCM SGF following the KAMIS 225 billing process.  
\*\*Remember the units must be entered into KAMIS by the 15<sup>th</sup> of the month.

### EXAMPLES:

**April 15, 2009** assessment completed:

- Customer already has TXIX. Bill assessment units to TCM via the MMIS.
- Assessment units are not entered onto KAMIS POC
- Assessment units must be entered onto paper POC

**April 21, 2009** assessment completed:

- Customer applied to SRS on April 25<sup>th</sup>. Medicaid determination must be made by SRS before TCM billing may occur.
- Customer is determined not Medicaid eligible May 23<sup>rd</sup>
- Assessment units must be entered onto KAMIS POC
- Assessment units must be entered onto paper POC
- Bill assessment units to TCM SGF via the KAMIS 225 process with units entered into KAMIS by June 15<sup>th</sup>

**May 14, 2009** assessment completed:

- Customer applied to SRS on May 5th. Medicaid determination must be made by SRS before TCM billing may occur.
- Customer is determined Medicaid eligible June 10<sup>th</sup> to be effective May 1<sup>st</sup>;
- Bill assessment units to TCM via the MMIS
- Assessment units are not entered onto KAMIS POC
- Assessment units must be entered onto paper POC

**May 29, 2009** contact made to schedule assessment:

- Assessment completed June 2<sup>nd</sup>
- Customer applied to SRS on June 5<sup>th</sup>. Medicaid determination must be made by SRS before TCM billing may occur.
- Customer is determined Medicaid eligible effective June 1st
- Bill contact units that occurred in May to TCM SGF
- Bill assessment units that occurred in June to TCM via the MMIS
- Only TCM SGF units are entered onto KAMIS POC
- Assessment units are not entered onto KAMIS POC
- All assessment units must be entered onto paper POC

Please refer to the following website for additional information:

[http://www.aging.state.ks.us/TCM/TCM\\_index.html](http://www.aging.state.ks.us/TCM/TCM_index.html)

## **Appendix C: Expedited Services Delivery (ESD)**

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### **How it works:**

The TCM will receive a referral and complete the home visit. If the customer meets the functional eligibility criteria, the TCM will complete the ESD worksheet to determine if they would be an ESD candidate. If so, the TCM would contact potential providers and develop the POC. The TCM would have up to seven (7) days to get services started. A NOA would be sent to the provider indicating these services are only to be provided for 45 days under the Expedited program, and the provider is guaranteed payment under this program either through HCBS or ESD (SGF). The NOA will tell the provider not to bill MMIS or KDOA until a Medicaid determination has been made.

### **For ALL ESD participants:**

The CME/TCM will enter the UAI into KAMIS. CME/TCM will select “Yes” on the Expedited Indicator to flag the POC as expedited and to trigger KAMIS to populate the UAI/POC information into the “ESD Worklist”

All ESD customers must sign and date the Expedited Service Delivery Agreement, indicating agreement to its terms.

### **For TXIX Medicaid eligible participants:**

The SRS eligibility worker notifies the TCM via the ES-3160 of TXIX Medicaid eligibility. The TCM then has three (3) working days to input the Medicaid ID number into the “ESD Worklist” in KAMIS. KDOA POC approvers will cross check MMIS for proper eligibility and review KAMIS generated case log notes for confirmation of ESD participation, thereby allowing for back-dating approval to be given.

Upon receiving POC approval from KDOA, the TCM will send a NOA to the customer and the provider indicating the customer has Medicaid eligibility effective from the date of start of services.

### **For TXIX Medicaid non-eligible participants:**

The SRS eligibility worker notifies the TCM via the ES-3160 of non-eligibility for TXIX Medicaid. The TCM has three (3) working days to input the end date of ESD services into KAMIS in the “ESD Worklist”. KAMIS will automatically default to one (1) unit in the last partial month of services. The TCM will need to pro-rate the units for the last month of service, and use the discharge code of "98" for closure of service. The TCM will send a NOA to the customer and the provider indicating the customer did not qualify for TXIX Medicaid and services are ending.

## **Appendix C: Expedited Services Delivery (ESD)**

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### **TCM PROCESS:**

1. Referral is called into the CME and TCM is assigned the case.
2. TCM completes the UAI, HCBS/FE Expedited Service Delivery Financial Screening Worksheet, and ESD Agreement.
3. A CSW and POC is developed using the same process as HCBS/FE. The case is started within seven (7) days of UAI completion. Oral Health Services and Assistive Technology cannot be on the POC until Medicaid eligibility is approved.
4. CME/TCM data enters UAI and POC (using HCBS/FE process) into KAMIS and checks Y/N for Expedited Services qualified. **Do not pend POC to KDOA at this time.** The TCM has the ability to revise the POC as needs increase/decrease.
5. TCM will send the NOA to the customer and the provider to start ESD services (use KDOA examples).
6. TCM will follow up with the customer and the SRS eligibility worker on the 10th day to ensure the customer has applied for Medicaid. If Medicaid has not been applied for by the 10th day, close the case immediately. (Timely notice is not required in this instance).
7. CME/TCM monitors ESD Worklist on KAMIS daily for customer status and follows up with the SRS eligibility worker as the customer nears the end of the 45 days of ESD to begin closure/transfer of services to the appropriate funding source.
8. Customers are eligible to receive ESD one time per year.

### **TXIX Medicaid ELIGIBLE CUSTOMER:**

1. TCM will enter customer's Medicaid ID number into ESD Worklist on KAMIS within three (3) working days of receiving notification of TXIX Medicaid eligibility. KAMIS will automatically:
  - a. switch POC line items to pending status;
  - b. enter case log in the system; and
  - c. pend the POC to appropriate KDOA POC approver.
2. TCM will submit the CCE paperwork to KDOA (as needed) for approval.

## **Appendix C: Expedited Services Delivery (ESD)**

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3. After KDOA approves the system POC, the TCM will send a second NOA (use KDOA example) to the customer and the provider indicating customer has TXIX Medicaid eligibility. The provider may now bill MMIS for services rendered.

### **NOT TXIX Medicaid ELIGIBLE:**

1. TCM will enter the end date of ESD services on ESD Worklist in KAMIS within three (3) working days of notification from SRS eligibility worker of non-eligibility for TXIX Medicaid. The end date of services is three (3) working days from SRS notification. KAMIS will automatically update the POC by:
  - a. end-dating the existing ongoing line with the last date of that month;
  - b. adding a line for partial months; and
  - c. defaulting all units to one (1) unit.
2. The CME/TCM must amend the KAMIS POC to pro-rate the units in the last partial month of services.
3. TCM will use discharge code "98" for closure of services.
4. TCM will send a second NOA (use KDOA example), informing the provider to stop ESD services and to bill the CME for services rendered via the 225 billing process.
5. CME/TCM will assist providers with payment for services provided to ESD customers.
6. TCM will work with customer to switch to other funding sources, if available.

Please note: Attendant care services are written in HCBS/FE units (1 unit = 15 minutes)

### **PROVIDER PROCESS:**

1. The provider will work with the TCM to staff the ESD case so services will be available to the customer in seven (7) days or less.
2. The provider will receive the ESD NOA, CSW, and POC from the TCM. The NOA will indicate that this is an expedited service case and to begin services even though the customer does not yet reflect TXIX Medicaid eligibility.
3. The provider will provide services in accordance with the NOA and CSW.

## **Appendix C: Expedited Services Delivery (ESD)**

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4. The provider will follow HCBS/FE documentation requirements from the start of expedited services to ensure proper documentation is available for post payment review in the event the customer meets TXIX Medicaid eligibility.
5. The provider agrees not to bill the CME (KAMIS) or the Medicaid fiscal agent (MMIS) until they have been notified by the TCM of the customer's eligibility determination, which may take up to 45 days.
6. The provider will receive a second NOA with the following information:
  - a. TXIX Medicaid eligibility has been approved and they need to bill the Medicaid fiscal agent/MMIS for services rendered; or
  - b. TXIX Medicaid eligibility has been denied and they need to bill CME via the KAMIS 225 process for services rendered. This NOA will also advise the provider to stop service delivery.
7. The provider will submit units provided to the CME for data entry into KAMIS using the 225 billing process. KDOA will process the payment back to the CME, and the CME will reimburse the provider for services rendered.

PLEASE REFER TO THE FOLLOWING WEBSITE FOR ADDITIONAL INFORMATION:  
[http://www.aging.state.ks.us/TCM/TCM\\_index.html](http://www.aging.state.ks.us/TCM/TCM_index.html)



## **Appendix D: Effective Dating Requests**

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This Effective Dating Requests process gives the KDOA Approvers access to the requests so proper coverage will occur when staff is out of the office. It also reduces the amount of paper.

### **Approval Process:**

All effective dating requests shall be submitted through the EDR web application. For consistency and ease of confirming approvals for the POC review, the following is the required information for each effective dating request:

- CME
- TCM Name (first and last)
- Customer Name (first and last)
- Beneficiary Number
- Social Security Number
- Start/Effective Date
- POC Cost (including the ACCC)
- Criteria Met
- Brief Description of Situation
- All FE services being added or increased
- A statement indicating if an ATR is required or not required. If an ATR is required, has it been processed by KDOA.

Once KDOA reviews the request, the approved start/effective date will be provided. The CME/TCM must enter the POC into KAMIS within three (3) working days of discharge, correction, or approval, as applicable and in accordance with Section 3.5.5.E. Once the EDR has been approved, the CME continues to have three (3) working days to enter the POC.

If the POC has not been entered within the required timeframe, an e-mail will be sent to the TCM and Supervisor to determine the status of the EDR/POC. The TCM will be given seven (7) working days from the date of the e-mail to respond and enter the POC onto KAMIS. If a response is not received within seven (7) days, the EDR will be revoked, and the CME will be responsible for paying the provider(s) for services rendered.

### **Denial process:**

If the request is denied, KDOA will respond to the TCM with the reason for denial.

## **Appendix E: Assistive Technology Authorization**

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1. The Assistive Technology (AT) Request is the turn-around document utilized for the authorization process.
2. TCM may send the Notice of Action to the customer and provider authorizing AT request upon receipt of KDOA's approval of the Assistive Technology Request.
3. The following conditions must be met for an AT request to be authorized:
  - a. the request must be within the scope of the service (see FSM Section 3.4.1.B);
  - b. the item or modification must be cost-effective;
  - c. the AT service information must be added to the KAMIS Plan of Care within three (3) working days of the KDOA approval; and
  - d. if the AT request is for a home modification, the TCM must also submit the Assistive Technology Home Modification Proposal (SS-030) at least two bids that contain the modification and itemized cost and required signatures. (Exceptions to the two bid minimum for home modifications in rural areas may be obtained from the AT reviewer.)
4. The AT purchase must be implemented with the time frame authorized by the AT reviewer.

## **Appendix F: Plan of Care Approval Information**

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Customers must have current eligibility and coding before review and approval by the KDOA POC Approver. If POC issues or corrections are identified, the CME shall hold the POC in their workload until the POC is able to be pended back to KDOA for approval.

KAMIS case log notes should include, but not be limited to, the following:

- Statement indicating whether customer or TCM requested service decrease or end;
- Brief explanation of what changes are being made;
- Start date of change (adding/increase/decrease);
- Whether or not effective dating has been approved;
- If a previously approved client obligation is being changed to \$0;
- Statement indicating if an ATR is required or not. If required; has it been processed by KDOA.

All KAMIS POCs submitted to KDOA must be pended to the Level I POC Approver's workload. POCs with Assistive Technology may be pended directly to the Assistive Technology Reviewer's workload.

Plan of Care (POC) approval timeframes are as follows:

- POCs are to be approved within 7 working days of submission to KDOA

Note: The date of data entry is not included in the 7 working day time frame for approval.

If KAMIS POC corrections are necessary, the CME must make the corrections and pend back to KDOA allowing adequate time for approval to occur before the change is to be effective. Failure to do this may result in the effective date of the change being extended by the CME and resubmitted to KDOA.

## **Appendix G: HCBS/FE Waiting List**

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The Kansas Department on Aging (KDOA) may establish a waiting list for the Home and Community Based Services for the Frail Elderly (HCBS/FE) program as needed. The number of customers to be served will be determined by the program's budget in each fiscal year. The waiting list will remain in place as long as needed for the program to remain within budget.

### **A. Who will be on the waiting list?**

1. Customers who apply for HCBS/FE after implementation of a waiting list and who meet the functional eligibility criteria for HCBS/FE will be placed on the waiting list. Nursing facility residents and Senior Care Act (SCA) and Older Americans Act (OAA) program customers that meet the HCBS/FE functional eligibility criteria may be on the waiting list.
2. If a former HCBS/FE customer's financial eligibility has been reinstated by the end of the month following the month of closure, his or her HCBS/FE case may be reinstated. The customer shall not be placed on the waiting list.
3. Customers eligible for Senior Care Act and Older Americans Act and HCBS/FE may only be placed on one program's waiting list.

### **B. How will customers be placed on the waiting list?**

1. Customers will be placed on the waiting list on a first come, first served basis, which shall be based on the date and time the required documentation is received by KDOA.
2. Customers will be placed in the priority section of the waiting list on a first come, first served basis if they meet at least one of the following priority criteria:
  - a. they require protection from confirmed abuse, neglect, or exploitation;
  - b. they are at the end stages of a terminal illness as determined by their primary care physician;
  - c. they are at-risk of serious harm due to the loss of their primary caregiver within the last 30 days, due to hospitalization, nursing facility placement, or death; or
  - d. they have lived in an assisted living facility, residential health care facility, boarding care facility, or home plus for at least 90 days and are at risk of losing their housing because they are within three (3) months of spending down their resources (Note: The facility shall work with the customers to ensure they are within three (3) months of spending down their resources prior to submitting documentation for priority consideration).

## **Appendix G: HCBS/FE Waiting List**

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3. Customers that relocate to another planning and service area shall retain their place on the waiting list. (See Section 3.5.14 for responsibilities regarding the transfer of files.)

### **C. Waiting List Procedures**

1. If the customer applies for HCBS/FE through the Department of Social and Rehabilitation Services (SRS), Economic and Employment Support (EES) will notify the customer's CME via the ES-3160 form.
2. If the customer applies for HCBS/FE through the CME and is not Medicaid eligible, the CME will refer the customer to the SRS office to begin the Medicaid application process.

(Note: EES will process the Medicaid application based on independent living methodologies and other categorical requirements with the knowledge that HCBS/FE services are not available at the time of application. The CME will be notified of the results of the Medicaid eligibility determination via the ES-3160 form.)

3. The CME shall determine whether the customer is functionally eligible for HCBS/FE using one of the following:
  - a. a CARE assessment that is less than 365 days old and a completed LTC Services Threshold Guide; or
  - b. the first two pages of a UAI that is less than 365 days old.
4. KDOA will not pay for an assessment of an HCBS/FE applicant that had a CARE assessment or UAI completed within the last 365 days if data from that assessment indicates he or she would be functionally eligible for HCBS/FE.
5. If the HCBS/FE applicant is not functionally eligible for HCBS/FE based on the CARE or UAI data or has not had one of those assessments, KDOA will pay to complete the first two pages of the UAI to determine whether the customer would be functionally eligible for HCBS/FE.
6. If the customer is functionally eligible for HCBS/FE, the CME shall determine whether the customer will be submitted for priority consideration based on the criteria in B.2 above.
7. If the customer requests nursing facility placement, the assessor shall refer the customer to the CARE program and notify the SRS office of the customer's choice via the ES-3160 form.

## **Appendix G: HCBS/FE Waiting List**

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8. If the customer requests HCBS/FE and meets functional eligibility criteria, the assessor shall explain to the customer that there is a waiting list and the customer's name will be placed on the list. The Customer Choice Form is not to be signed at this time.
9. The CME Assessor or CME Waiting List Coordinator shall send the results of the customer's functional eligibility determination to the SRS office via the ES-3160 form.
10. The CME Assessor or CME Waiting List Coordinator shall send the required documentation to the KDOA Waiting List Coordinator. If the customer meets any of the priority criteria, the CME shall submit additional documentation that supports the priority consideration.
11. If the CME assessor has requested priority consideration, the HCBS/FE Program Manager will notify the CME Waiting List Coordinator via email whether the customer has been placed in the priority section of the waiting list. The CME shall send the customer a Notice of Action regarding his or her placement on the waiting list.

### **D. Notification of waiver opening**

1. The KDOA Waiting List Coordinator will notify the CME Waiting List Coordinator and the KDOA POC Approver via email identifying the customer whose case may be opened.
2. The CME has 90 days from notification of waiver opening to have the KAMIS plan of care in approved status.
3. If prior to the case being opened the CME finds that the customer does not want or is not eligible for HCBS/FE, the CME Waiting List Coordinator shall notify the KDOA Waiting List Coordinator via the Notice of Customer Closure (SS-019).
4. Those customers that have not met Medicaid eligibility requirements within the 90 day time frame will be removed from the waiting list.

## **Appendix H: HCBS/FE Crisis Exception Process**

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### **Purpose:**

The Crisis Exception Criteria Checklist (SS-049) is the turnaround document utilized for the authorization process on any of the following four services with crisis exception limitations:

- Assistive Technology
- Comprehensive Support
- Oral Health Services
- Sleep Cycle Support

### **Submitting a Crisis Exception Request:**

The TCM will review with the customer or their representative the Plan of Care and the current situation to determine if the customer requires any of the four services with crisis exception limitations to ensure the customer's health and welfare.

The TCM will complete the Crisis Exception Criteria Checklist by answering the relevant sections for the service(s) being requested. The TCM shall provide a description of the customer's situation in the Narrative Section by providing pertinent facts as to how the customer's health and welfare depends upon the requested service(s).

The TCM will fax the Crisis Exception Criteria Checklist along with any supporting documentation to the KDOA Program Help Desk.

### **KDOA Determination:**

The KDOA Crisis Exception Committee will provide determinations to the CMEs on a weekly basis.

The TCM may be contacted if additional information or clarification is needed. The KDOA Crisis Exception Committee will make a determination once all information is received.

Once a determination has been made, the KDOA Crisis Exception Committee will indicate approval or denial of the request and, if approved, will indicate for which service(s) the exception has been granted. KDOA will indicate the date that the exception was processed and may also provide additional comments or instructions to the TCM.

KDOA will notify the TCM of the determination by faxing the completed Crisis Exception Criteria Checklist to the TCM.

## **Appendix H: HCBS/FE Crisis Exception Process**

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### **Approved Crisis Exception:**

KDOA will indicate in the customer's KAMIS case log the service(s) approved for an exception.

#### **For Assistive Technology:**

The CME/TCM will submit the Assistive Technology Request Worksheet to KDOA and follow the authorization process stated in Appendix E.

#### **For Comprehensive Support and Sleep Cycle Support:**

The CME/TCM will data enter the POC into KAMIS utilizing the established time frames for Levels I, II, and III POCs. The TCM will submit a Cost Cap Exception Request packet if applicable.

Once KDOA has approved the POC, the TCM will send an NOA (KDOA-904) to the customer or their representative and the provider(s), notifying them of the authorized services.

#### **For Oral Health Services:**

The CME/TCM will contact the customer and obtain the provider name. The TCM will data enter the POC into KAMIS with the following information:

Service = MOHS

Funding = HCBS/FE

Provider = Dentist name/clinic

Units = "999"

Per = Visit(s)

Units Monthly = "999"

Start Date = Date specified in comments section of the Crisis Exception Checklist

End Date = Date specified in comments section of the Crisis Exception Checklist

Monthly Cost = "0"

Once KDOA has approved the POC, the TCM will send an NOA (KDOA-904) to the customer or their representative and the provider(s) with the following statement:

"The customer has been approved to receive Oral Health Services funded through the HCBS/FE waiver. The necessary dental services provided to the customer must be listed in the Covered Benefit Plan and reimbursed at the established Medicaid rate as identified in the fee schedule. These services must be performed during the date range specified in this notice."

### **Denied Crisis Exception:**

KDOA will notify the TCM of the denial by faxing the completed Crisis Exception Criteria Checklist to the TCM.



## **Appendix H: HCBS/FE Crisis Exception Process**

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The CME/TCM will send an NOA (KDOA-904) to the customer or their representative, notifying him or her of the denied request and the customer's right to appeal the denial (Rights and Responsibilities form SS-012).

TCM will follow up with the customer or their representative to identify alternative resources to meet the customer's health and welfare needs.

If the customer's status or circumstances change, the TCM may submit another Crisis Exception request.

## Appendix I: Customer Service Worksheet - Time Allowances

<i><b>SERVICE</b></i>	<b>Maximum Time Allowed</b>	<b>Reasons for Additional Time*</b>
Bathing/Grooming	30 minute maximum/day; includes all bathing/grooming tasks listed; less time will be given if fewer tasks needed	Cognitive impairment in 3 or 4 of the cognition questions (specify if there is combativeness); stroke with physical limitations (specify the limitations)
Dressing/Undressing	15 minute maximum/occurrence (2X/day); less time will be given if only limited assistance required, e.g. bra or shoes only	TED hose; incontinent episodes that require change of clothes (specify frequency); stroke with physical limitations (specify limitations)
Toileting	10-15 minute maximum for assistance/occurrence (waiting time is not to be included); less time will be given if only cueing	Toileting schedule every 2 hours (less frequently during customer's sleeping time – specify staffing)
Mobility (Includes Transfer & Walking)	30 minute maximum/day for assistance for transferring/walking/mobility – time allowed for one on one supervision only if diagnosis of severe dementia or other severe cognitive impairment.	Use of a mechanical lift is needed; range of motion exercises (specify exercises)
Eating	15 minute maximum/occurrence	Cognitive impairment in 3 or 4 of the cognition questions leading to continued reminding or total feeding; stroke with physical limitations (specify limitations); choking risk (specify cause)
Meal Preparation (Breakfast/Lunch/ Supper/Snack)	7 hours maximum/week; less time if customer has HMEL; must divide if both spouses are HCBS customers or multiple HCBS customers live in same home	None
Shopping	2 hours maximum/week; must divide if both spouses are HCBS customers or multiple HCBS customers live in same home	None
Money Management	Informal	Informal
Accompanying to Medical Appointments	No time allowed	Cognitive impairment in 3 or 4 of the cognition questions or LOC score of 3 or 4 in mobility and no family or friends present.
Telephone Usage	Informal	Informal
Housekeeping/ Laundry	4 hours maximum/week	Incontinent or doing laundry frequently (specify number of loads and frequency); laundry facilities outside of home or apartment complex
Management of Medications/ Treatments	3.5 hours maximum/week	Prescribed treatments; wound care (specify treatment); health maintenance activities beyond normal medication set-up and administration (specify tasks)

\*Additional time may be approved by KDOA for extraordinary circumstances

## **Appendix I: Customer Service Worksheet - Time Allowances**

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### **Submitting an Additional Time Request (ATR):**

The TCM will review with the customer or their representative the Customer Service Worksheet (CSW) detailing the current needs to determine if the customer requires additional time above the established maximums to ensure customer's health and welfare.

The TCM must complete the "Additional Time Request" web application. This will include scanning the CSW, with the requested additional time indicated, into the web application. The TCM shall provide a description of the customer's situation and include pertinent facts as to how the customer's health and welfare depends on the requested time.

The TCM will submit for approval the "Additional Time Request" to KDOA. Three additional days to the established time frames for Level I, II, and III POC approval will need to be allowed.

### **Submitting an ATR due to change in condition;**

The TCM must submit an ATR when the customer's POC requires changes that exceed the standard time limitations and the customer does not currently have an approved ATR.

The TCM must submit a new ATR when a customer experiences a change in condition requiring more time for a specific task above and beyond the approved ATR.

The TCM shall not submit another ATR to KDOA if the POC remains unchanged at reassessment.

### **KDOA Determination:**

KDOA will provide determinations to the CMEs according to the established time frames. The TCM may be contacted if additional information or clarification is needed. KDOA will make a final determination once all information is received.

Once a determination has been made, KDOA will indicate approval or denial of the request and if approved, will indicate for which ADL(s)/IADL(s) the approval has been granted. KDOA will advise the TCM of the determination by e-mail notification.

**3.6 Senior Care Act**

**3.6.1 Program Description and Outcomes**

The Senior Care Act (SCA) program was established by the Kansas Legislature to assist older Kansans who have functional limitations in self-care and independent living, but who are able to reside in a community based residence if some services are provided. The program provides in-home services to persons who contribute to the cost of services based on their ability to pay.

The SCA program shall be measured by the following Kansas Department for Aging and Disability Services (KDADS) strategic plan outcomes:

- Assessments capture a picture of the customer’s needs;
- Informal caregivers are appropriately supported in their caregiving role;
- Services provided across the continuum meet senior’s expectations of quality;
- Case management provides a cost-effective means to coordinate services;
- Area agencies on aging (AAAs) target services to the identified populations;
- Seniors live in their family homes later into the life cycle;
- Seniors remain a part of the larger community, thereby enhancing their quality of life; and
- Transition to nursing home services occurs later in the life cycle.

**3.6.2 Authorities (as amended)**

The program is governed by KSA 75-5926 et seq. and KAR 26-8-1 through 26-8-15.

**3.6.3 Definitions (KAR 26-8-1)**

**Family** – See Section 1.1 for a definition of family.

**Income** - means the monthly sum of income received by a family from the following sources:

- a. Gross wages or salary;
- b. income from self-employment;
- c. social security;
- d. dividends, interest, income from estate or trusts, rental income, or royalties;
- e. public assistance or welfare payment;
- f. pensions and annuities;
- g. unemployment compensation;
- h. workers compensation;
- i. alimony;
- j. veteran's pensions; and
- k. adjusted net farm income.

**3.6.3 (cont.)**

**Liquid Assets** - means cash on hand; funds in checking, savings, money market, and individual retirement accounts; stocks; bonds; savings bonds; certificates of deposit; the cash value of life insurance policies; and mutual funds.

**One-time service** - means an activity that is not intended to be ongoing (less than three months per 365 days) and has a unit of service of one dollar.

**3.6.4 Eligibility Criteria (KAR 26-8-2)**

A. General

1. Each customer must be a resident of Kansas (see Section 1.1 for a definition of Kansas resident); and
2. Each customer must be 60 years of age or older.

B. Functional

To be eligible for SCA services, the customer must meet the **Long Term Care Threshold criteria**, based on the results of the Long Term Care (LTC) Threshold Guide of the Uniform Assessment Instrument (UAI) as follows:

1. The customer has impairment in a minimum of two (2) Activities of Daily Living (ADLs) with a minimum combined weight of six (6); and impairment in a minimum of three (3) Instrumental Activities of Daily Living (IADLs) with a minimum combined weight of nine (9); and a total minimum level of care weight of 26; or
2. The customer has a total minimum weight of 26, with at least 12 of the 26 being IADL points and the remaining 14 being any combination of IADL, ADL, and/or Risk Factor points.

C. Customers that receive only an assessment are not subject to the functional eligibility criteria in B.

D. Medicaid home and community based services customers shall be eligible to receive only SCA services that are not funded through the Medicaid program.

**3.6.5 Service Provision**

- A. Prior to service implementation, an assessment must be completed and the customer must be determined eligible for the program pursuant to Section 2.6.

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**3.6.5 (cont.)**

- B. Qualified Uniform Assessment Instrument (UAI) Assessors shall adhere to the requirements in Section 2.6.
- C. Case managers (CMs) shall adhere to all responsibilities as identified in Section 3.1.
- D. A comprehensive list of services funded by the SCA program is listed in the Service Taxonomy.
- E. Services must begin within seven (7) calendar days of the determination of eligibility (date of assessment). The customer's case file must clearly document the reason(s) for any exception to this timeframe. The following consist of acceptable reasons why a customer's services are not delivered within the seven (7) calendar days.
  - 1. Service provider limitations- While AAAs are expected to do their best to ensure that service providers are available for the services funded in their service area, provider availability cannot be guaranteed.
  - 2. Resource limitations- SCA services may be limited by the amount of state and local resources (KSA 75-5928(c)).
  - 3. The customer requests that services be delayed for seven (7) or more days.
- F. Customer Fees
  - 1. The SCA program is a fee-for-service program. Each customer shall be charged a fee, which is taken from the sliding fee scale and based on the customer's family size, monthly income, and liquid assets, which are recorded on the Uniform Assessment Instrument. (See Section 1.1 for a definition of family.)
  - 2. The customer's fee shall be revised if the monthly income and/or liquid assets have changed as determined during the customer's annual reassessment or an assessment completed due to significant change in condition. (See Section 1.1 for a definition of significant change in condition.)
  - 3. The Notice of Action shall reflect customer fee percentage and estimated monthly customer responsibility.
  - 4. The sliding fee scale is revised annually to reflect changes in the poverty scale. KDADS will publish revisions to the sliding fee scale in the Kansas Register prior to its implementation.
  - 5. The customer's fee shall not include case management or assessment.

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**3.6.5.F (cont.)**

- 6. If a customer refuses to disclose his or her income and liquid assets, then that customer shall pay 100% of the cost of the service (KAR 26-8-7).

**G. Available Service Providers**

A customer is eligible for SCA services until such time as service providers or other resources are unavailable to implement all services on the plan of care. It is the responsibility of the CM to identify and locate service providers and/or community resources.

**H. Interruption of Services**

SCA services, with the exception of Personal Emergency Response service, shall be suspended during a short-term stay (planned brief stay or temporary stay) using an NOA (See FSM 1.3.5). If the end date is not known at the time of the initial NOA, a second NOA must be sent to reinstate services. The SCA case shall remain open for case management services and payment of Personal Emergency Response and Financial Management Services for a period no longer than two calendar months following the month in which services were suspended (e.g. if a short-term stay began on July 3<sup>rd</sup>, the case could remain open until September 30<sup>th</sup>).

**3.6.6 Self-Directed Attendant Care and Homemaker Services**

**A. Self-Directed Services Description**

Attendant care and homemaker 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. Attendant care and homemaker services may be provided in the individual's choice of housing, including temporary arrangements.

<b>IADLs</b>	<b>ADLs</b>	
<ul style="list-style-type: none"><li>• Shopping</li><li>• House cleaning</li><li>• Meal preparation</li><li>• Laundry</li><li>• Medication setup, cueing, or reminding and treatments</li><li>• Life management (financial matters, i.e., bill paying)</li></ul>	<ul style="list-style-type: none"><li>• Bathing</li><li>• Grooming</li><li>• Dressing</li><li>• Toileting</li></ul>	<ul style="list-style-type: none"><li>• Transferring</li><li>• Walking/Mobility</li><li>• Eating</li><li>• Accompanying to obtain necessary medical services</li></ul>

**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/homemaker services. The customer’s representative may be an individual acting on behalf of the customer, an activated durable power of attorney for health care decisions, a guardian, and/or conservator. If the customer or representative chooses to self-direct attendant care or homemaker services, he or she is responsible for making choices about those services, including hiring, supervising, and terminating the employment of attendants or homemakers; understanding the impact of those choices; and assuming responsibility for the results of those choices. Self-directed attendants/homemakers are subject to the same quality assurance standards as other attendant care and homemaker service providers including, but not limited to, completion of the tasks identified on the Customer Service Worksheet (CSW).

According to KSA 65-1124(1), 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 medical care provider or registered nurse.

**B. Self-Directed Care Limitations**

1. All customers with self-directed services will have mandated case management.
2. All customers with self-directed services must have a CSW, and it must be signed by the customer or his/her representative.
3. Attendants must be 18 years of age or older.
4. A customer who has a guardian and/or conservator cannot choose to self-direct his or her attendant care or homemaker services; however, a guardian and/or conservator can make that choice on the customer’s behalf.
5. While a family member may be paid to provide attendant care or homemaker services, a customer’s spouse shall not be paid to provide these services unless one of



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the following criterion from KAR 30-5-307 is met and prior approval is received from the KDADS SCA program manager:

- a. Three SCA provider agencies, or the number of SCA providers in the customer's county of residence, furnish written documentation that the customer's residence is so remote or rural that SCA services are otherwise completely unavailable;
  - b. 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);
  - c. Three SCA providers, or the number of SCA providers in the customer's county of residence, furnish written documentation that delivery of SCA services to the customer poses serious health or safety issues for the provider, thereby rendering SCA services otherwise unavailable; or
  - d. 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.
6. The CM and the customer or their representative will use discretion in determining if the selected attendant/homemaker can perform the needed services.
  7. Covered services are limited as defined within the approved Plan of Care (POC).
  8. Transportation is not covered with this service.
  9. 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 case log by the CM for a two-person lift or transfer.

**C. Self-Directed Care Requirements**

1. A guardian, a conservator, a person authorized as an activated durable power of attorney (DPOA) for healthcare decisions, or an individual acting on behalf of a customer cannot choose himself or herself as the customer's paid attendant or homemaker. If the designation of the appointed representative is withdrawn, the individual may become the customer's paid attendant/homemaker after the next annual review or a significant change in the customer's needs occurs prompting a reassessment.
2. SCA services, with the exception of personal emergency response monitoring, cannot be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive services.

D. Termination of the Self Directed Care Option

1. The following situations warrant termination of the self-directed care option if it is documented that the CM has attempted to remedy the situation and has involved the customer's payroll agent (FMS provider), as needed:
  - a. If the customer does not fulfill the responsibilities and functions as outlined in Section 3.6.6.E;
  - b. If the health and welfare needs of the customer are not met as observed by the CM or confirmed by the Kansas Department for Children and Families (DCF) Adult Protective Services (APS);
  - c. If the attendant or homemaker has not adequately performed the necessary tasks and procedures. For attendant care services, this would include not following the CSW;
  - d. If the customer/representative, attendant or homemaker has abused or misused the self-directed care option, such as, but not limited to the following:
    - i. The customer/representative has directed the attendant or homemaker to provide, and the attendant or homemaker has in fact provided paid attendant care or homemaker services beyond the scope of the CSW and/or POC;
    - ii. The customer/representative has continually directed the attendant or homemaker to provide care and services beyond the limitations of their training, or the health maintenance activities training was provided to the attendant or homemaker in a manner that will have an adverse effect on the health and welfare of the customer.
    - iii. The customer/representative has directed the worker to provide, and the worker has in fact provided, tasks and procedures beyond the scope of their authorized services; or
    - iv. The customer/representative has submitted time sheets for services beyond the scope of the CSW and/or POC.
  - e. If the customer, family member, or other person present in the household committed a Level I Safety Offense as specified in Section 3.1.11 and did not comply with the action plan to correct the problem.
2. The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:

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- a. The customer has falsified records that result in claims for services not rendered;
  - b. The customer has Health Maintenance Activities or Medication Setup and the customer's medical care provider or RN (Registered Nurse) no longer authorizes the customer to self-direct these services; or
  - c. The customer has committed a fraudulent act.
  - d. The customer refused to sign the "Customer Code of Conduct" as required in FSM 3.1.11.B.
  - e. The customer, family member, or other person present in the household committed a Level II Safety Offense as specified in Section 3.1.11.
3. A timely notice of action (NOA) shall be sent to the customer prior to the effective date for termination of the customer's participation in the Self-Directed Care Option (see Section 1.3 for a definition of Timely NOA).

**E. Customer Responsibilities under the Self-Directed Care Option**

As the employer of the attendant or homemaker, there are numerous functions of the Self-Directed Attendant Care or Homemaker Services Option that must be performed by the customer/representative. The customer/representative is responsible for the activities listed below:

1. Recruit attendants or homemakers and backup workers;
2. Select an attendant or homemaker, assign hours within the limits of the service authorization, and refer him or her to a payroll agent for registration;
3. Obtain a completed Physician/RN Statement that has been signed by a medical care provider or registered nurse if the customer has health maintenance activities or medication setup provided through Attendant Care Services. (Note- the CM must ensure that the Physician/RN Statement is completed in its entirety and received prior to implementing health maintenance activities or medication setup.);
4. Collect basic information in order to establish the attendant's/homemaker's files with respect to the identity of the attendant/worker (i.e., name, address, phone number, etc.) and background (i.e., past work history and any relevant training) in the form of an application for employment;
5. Maintain continuous attendant or homemaker coverage in accordance with the authorization for services. This includes assigning backup during vacation, sick leave or other absences of the assigned attendant/homemaker and notifying the CM of these changes;

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6. Notify the attendant/homemaker and appropriate CM staff of any changes in their medical condition, eligibility, or needs that affect the provision of services, such as hospitalization, nursing facility placement, or need for more or less hours of service;
7. Provide training to each attendant or homemaker on the general duties and the specific tasks and procedures to be performed. Such training, however, does not qualify the attendant or homemaker to serve any other customer;
8. Transmit information to the attendant(s)/homemaker(s) in regards to pay, time and leave schedules, and time sheets;
9. Maintain separate time sheets on each attendant/homemaker providing services for the customer, monitor the hours attendants and homemakers work so that they do not exceed the amount authorized, verify hours worked, and forward the time sheets to the payroll agent;
10. Monitor the attendant/homemaker to ensure he or she has performed the necessary services;
11. Dismiss the attendant/homemaker if he or she is not performing the tasks assigned according to the CSW;
12. Dismiss the attendant/homemaker if needed;
13. Notify the CM or AAA and the payroll agent if there is a desire to discontinue the option to self-direct; and
14. Customers/representatives who choose to discontinue self-directing their services are requested to give ten (10) days notice of their decision to the CM to allow for the coordination of service provision.

**3.6.7 Service Limitations**

- A. Funds for purchase of service provided under the SCA shall be expended only when other sources of support for service provision are not available. The funds shall not replace Medicaid, Older Americans Act, community services block grant, Medicare, Veterans Administration (VA) benefits, and other state or federal funding sources that may be used to pay for needed services (KSA 75-5929(b)). Long-term care insurance shall also pay for services prior to SCA.
- B. The maximum monthly expenditure for services per customer shall be \$1,445. This amount shall not include expenditures for assessment, case management, and any one-time service (KAR 26-8-7).

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- C. The maximum expenditure for one time services is \$1,445 unless the expenditure is prior approved by KDADS.
  - 1. Prior approval of each one-time service over \$1,445 must be obtained from the KDADS SCA Program Manager.
    - a. Prior approval requests must be submitted by secure and/or encrypted e-mail from the AAA SCA Program Manager or AAA Director. Include “SCA One-Time Service Request” in the e-mail subject line for identification of priority need.
      - 1. Format of email must include the following:
        - i. Customer name, DOB and KAMIS ID number
        - ii. One-time service requested (correct Service Taxonomy code referenced)
        - iii. Provider name(s)
        - iv. Cost of one-time service
        - v. Is any portion or cost covered by Medicare or other programs?
        - vi. Specifically list other resources explored.
        - vii. Description of unmet need
        - viii. Upon request, price quotes from up to three vendors may be required
  - 2. Notification of KDADS approval/denial will be provided by e-mail within 72 hours of receipt from the fully completed request excluding weekend days and holidays.

**3.6.8 Compliance Standards**

**A. Confidentiality**

The AAA shall develop and maintain policies and procedures to implement the Health Insurance Portability and Accountability Act of 1996 and KAR 26-1-7, which protect the confidentiality of and guard against the unauthorized disclosure of information about individuals obtained through assessments and provision of services.

**B. Record Retention**

- 1. The AAA must maintain files that include the following written documentation: intakes, assessments, signed customer fee agreements, releases of information, records of services provided, reason for discharge, and other pertinent information.
- 2. Records must be maintained for a period of no less than five (5) years following the termination date of the contract.

**C. Customer and Provider Notification**

- 1. Prior to implementation of services and annually, the CM must review and discuss with the customer the Customer Service Worksheet (CSW), the Rights and

Responsibilities form (SS-12), the Customer Fee Agreement (SS-11), and a Customer Choice Form (SS-24). The customer must date and sign the Customer Fee Agreement and the Customer Choice Form. The CM must document discussion of form review in the case file.

2. AAAs must obtain approval in writing from KDADS prior to any additions or alterations to any program forms.
3. The AAA must follow the notification and appeals process as outlined in Section 1 of this manual.

**D. Billing**

1. Customers shall be billed at least quarterly.
2. The AAA must determine whether the customer has other sources of payment, i.e., long-term care insurance or VA benefits. If the customer does have another payment source(s), the AAA must inform the customer that a claim must be filed for the maximum benefit allowed from that source(s) to off-set any SCA funds expended.
3. All long-term care insurance or other available proceeds or benefits shall be deducted from the amount billed to KDADS for services provided.

**3.6.9 Program Administration**

**A. SCA Budget Requirements**

1. Any SCA budget or revised budget submitted must not exceed 18% in the category of "Administration." The 18% calculation shall be derived by dividing the SCA Budget Summary Page "Administration" line item by the "Total Cost" line item.
2. Any SCA budget or revised budget submitted must not exceed 18% in the category of "Case Management." The 18% calculation shall be derived by dividing the SCA Budget Summary Page "Case Management" line item by the "Total Cost" line item.
3. Any AAA with a reported waitlist may not reallocate SCA funds to other AAAs unless SCA funds reallocated are used by receiving AAAs in the areas of Attendant Care and Homemaker services.

**3.6.10 Service Discharge**

- A. Services provided under this act shall be terminated by the AAA for any of the following reasons (KAR 26-8-8 and other discharge options); numbering in this section corresponds to data entry codes in state designated MIS: some codes are reserved and not available for use:

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2. The customer died;
  3. The customer moved out of the planning service area;
  4. Customer moved to adult living facility with supportive services;
  5. Customer moved to nursing facility;
  6. The customer chose to terminate services (includes moving out of state);
  7. The customer is determined to be no longer safe in his or her own home;
  9. The customer's fees have not been paid, and 60 days have passed since the original billing date;
  10. The customer did not accurately report his or her income and liquid assets and chooses not to pay his or her applicable fees or no longer meets financial eligibility;
  11. The customer no longer meets functional eligibility;
  13. The program or service ended or was terminated;
  14. The service was provided one time;
  15. The service was discontinued due to lack of service provider or staff;
  21. The customer is a PACE participant.
  25. The customer's whereabouts is unknown; or
- B. At the discretion of the AAA, services provided under this act may be terminated for any of the following reasons (Note - A referral to more skilled or comprehensive services may be required) numbering in this section corresponds to data entry codes in state designated MIS: some codes are reserved and not available for use:
7. The customer's needs exceed service limitations;
  20. The customer and/or the customer's family substantially interfere with the provider's ability to deliver services, including refusing service and interfering with completion of work; this is used if the possibility exists that the customer or the customer's family is physically or verbally harming the worker or where violence has been previously noted; this reason for discharge can also be used when a customer or a member of the customer's family makes sexual advances, demonstrates sexually

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inappropriate behavior, uses sexually inappropriate language in the presence of staff, or any combination of such actions;

21. The customer transferred to another funding source for services;
23. The customer failed to sign or abide by the POC or CSW; or
29. The customer's condition improved and therefore services were discontinued, or fewer units are needed;
35. The customer's family or an informal support will provide this service;



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**Section 3.7**

**Community Based Income Eligible**

**Effective Date: July 1, 2001**

**Revision: 2001-02**

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This section has been revoked. See Section 3.6, Senior Care Act.

### 3.8 Family Caregiver Support Program (FCSP)

#### 3.8.1 Program Description and Outcomes

Title III E of the Older Americans Act (OAA) established the National Family Caregiver Support Program (NFCSP). The program in Kansas is known as the Family Caregiver Support Program (FCSP). The FCSP is designed to assist informal caregivers in the areas of health and finance, and in making decisions and solving problems related to their caregiving roles. The primary outcomes of this program are to ensure caregivers have access to information and resources and are appropriately supported in their caregiver roles.

#### 3.8.2 Definitions

- A. **Adult With a Severe Disability:** An individual who is 19 to 59 years of age with a severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that:
1. Is likely to continue indefinitely; and
  2. Results in substantial functional limitation in three or more of the major life activities specified in the definition of "Disability."
- B. **Care Recipient:** An individual who receives informal support from a qualified caregiver and meets one or more of the following criteria:
1. An individual 60 years of age or older;
  2. An individual less than 60 years of age with Alzheimer's disease or a related disorder with neurological or organic brain dysfunction;
  3. An adult, age 19 to 59, with a severe disability; or
  4. A child under 19 years of age.
- C. **Caregiver:** An adult family member or other individual who is an informal provider of in-home and community care to an older individual, an adult with a severe disability, or a child under 19 years of age.
- D. **Child:** An individual who is under 19 years of age.
- E. **Customer:** An individual who provides informal support to a care recipient.
- F. **Disability:** An incapacity attributable to mental or physical impairment, or a combination of mental and physical impairments, that result in substantial functional limitations in one or more of the following areas of major life activity:
1. Self care;
  2. Receptive and expressive language;
  3. Learning;

**3.8.2.F (cont.)**

4. Mobility;
  5. Self-direction;
  6. Capacity for independent living;
  7. Economic self-sufficiency;
  8. Cognitive functioning; or
  9. Emotional adjustment.
- G. Informal Support: Care is not provided as part of a public or private formal service program.
- H. Older Individual: An individual who is 60 years of age or older, or a person less than 60 years of age who has Alzheimer's disease or related disorder with neurological or organic brain dysfunction.
- I. Relative: A grandparent or step-grandparent of a child or severely disabled adult, or an individual related by blood, marriage, or adoption.

**3.8.3 Eligibility (OAA, Section 373(c))**

- A. Individuals must meet one of the following criteria to be eligible for services funded by the Family Caregiver Support Program.
1. A caregiver caring for an older individual or an individual who is less than 60 years old and has Alzheimer's disease or a related disorder with neurological or organic brain dysfunction.  
  
In order for the caregiver to receive respite and/or supplemental services, the care recipient must meet one of the following conditions:
    - a. Be unable to perform at least two (2) activities of daily living without substantial human assistance, including verbal reminding, physical cuing, or supervision; or
    - b. Require substantial supervision because he or she behaves in a manner that poses a serious health or safety hazard to him or her or to another individual due to a cognitive or other mental impairment.
  2. A grandparent or other relative or non-relative, providing care for a child or disabled adult, who meets the following conditions:
    - a. Is 55 years of age or older;
    - b. Lives with the child or disabled adult;

**3.8.3.A.2 (cont.)**

- c. Is the primary caregiver of the child or disabled adult because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the individual; and
  - d. Has a legal relationship to the child or disabled adult, such as legal custody or guardianship, or in the case of a child, is raising the child informally.
- B. In providing services under this program, the Area Agency on Aging (AAA) shall give priority for services to:
- 1. Caregivers who are older individuals with the greatest social need and with the greatest economic need, as defined in Section 1.1, with particular attention to low-income older individuals;
  - 2. Caregivers who provide care for individuals with Alzheimer's disease or related disorders with neurological or organic brain dysfunction; and
  - 3. Caregivers providing care for individuals with severe disabilities, including children with severe disabilities.

**3.8.4 Program Requirements**

- A. The AAA shall submit a Caregiver Support Program Plan according to the area plan requirements (OAA, Section 306).
- B. The AAA shall grant and/or contract with community based organizations to provide multifaceted systems of support services for caregivers, which may include grandparent and relative caregivers (OAA, Section 373(a)).
- C. The AAA must make use of trained volunteers to expand the provision of the available services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers and participants in community service settings.
- D. The AAA shall assure that its service providers:
  - 1. Can demonstrate interagency coordination;
  - 2. Have procedures in place to report and manage program income that may be received;
  - 3. Have the capacity to collect necessary data to demonstrate that persons receiving respite or supplemental services meet the eligibility criteria; and

**3.8.4.D (cont.)**

4. Have mechanisms in place to prioritize services to older individuals in accordance with Section 3.8.3.B.
- E. A Caregiver Assessment Plan (CAP) (SS-025) must be completed for each caregiver receiving services, excluding Assistance and Information. It is the AAA's responsibility to ensure that all required information is obtained.
- F. The AAA must follow the Notice of Action (NOA) requirements for all actions related to FCSP services as specified in Section 1.3.5 of the Field Services Manual.
- G. The AAA must follow the Grievance, Notice of Action, and Appeals policy in Section 1.3 of the Field Services Manual.
- H. The AAA must enter the required data from the III-E Caregiver Assessment Plan (CAP) into KAMIS before the 20<sup>th</sup> day of the month following the month in which services were provided. The Start Date entered into KAMIS allows providers of caregiver services to be reimbursed effective with this date of service.
- I. The AAA must verify the Group I Services provided and submit through the KAMIS 225 process before the 20<sup>th</sup> day of the month following the month in which services were provided.
- J. The AAA shall submit a monthly Financial Report (AS-003) to KDOA's Fiscal Services Manager by the 20<sup>th</sup> day of the month following the report month.
- K. The AAA must enter a semi-annual Title III-E Activity Report into KAMIS on or before April 20<sup>th</sup> and October 20<sup>th</sup> of each calendar year. This report must list all Group II Services (see Section 3.8.6.A.2).

**3.8.5 Program and Service Limitations**

- A. Title III-E funds shall be spent in addition to, and not supplant, any federal, state, or local government or AAA funds expended to provide caregiver services (OAA, Section 374).
- B. The AAA may expend no more than 10% of its federal and state service allocation to fund support services for individuals that meet the eligibility criteria in Section 3.8.3.A.2. This limitation does not include services provided to a grandparent or other caregiver providing care for an individual 19 to 59 years of age with a severe disability.
- C. The AAA may expend no more than 50% of its service allocation for Supplemental Services.

**3.8.5 (cont.)**

- D. Respite under this program is a temporary service in that it cannot be provided for more than seven (7) consecutive days.
- E. If the AAA chooses not to contract with a provider for purchase and delivery of Bathroom Items, a direct service waiver request must be approved by KDOA through the area plan process. (Refer to FSM Section 7.1.3.C)
- F. If the AAA chooses not to contract with a provider for purchase and delivery of Flex Service, a direct service waiver request must be approved by KDOA through the area plan process. (Refer to FSM 7.1.3.C.2)
- G. Prior approval of each Flex Service item or service purchase must be obtained from the KDOA Family Caregiver Support Program Manager.
  - 1. Prior approval requests must be submitted by e-mail from the AAA Family Caregiver Support Program Coordinator or AAA Director. Include “Flex Service Request” in the e-mail subject line for identification of priority need.
  - 2. Notification of KDOA approval/denial will be provided by e-mail within 72 hours of receipt from the original request excluding weekend days and holidays.
- H. The caregiver must be a resident of the state of Kansas in order to receive FCSP services, excluding Information and Assistance.
- I. A caregiver not living in the care recipient’s home (See Section 3.8.3) must live within a proximate geographical location to the care recipient that would facilitate in-home assistance daily, if needed.
- J. In the event of a care recipient’s death, a caregiver receiving Support Group services may continue receiving Support Group services for one year beyond the death of the care recipient.
- K. In the event of a care recipient’s death, a caregiver receiving Individual Counseling may continue receiving Individual Counseling for one year beyond the death of the care recipient.

**3.8.6 Services**

- A. The following services may be funded for caregivers, grandparents, or relative caregivers by the Family Caregiver Support Program:
  - 1. Group I:

**3.8.6.A.1 (cont.)**

- a. Individual Counseling;
  - b. Support Groups;
  - c. Caregiver Training (Group);
  - d. Caregiver Training (Individual);
  - e. Respite; and
  - f. Supplemental Services, which include:
    - i. Attendant and/or Personal Care;
    - ii. Bathroom Items;
    - iii. Chore;
    - iv. Flex Service;
    - v. Homemaker;
    - vi. Repair/Maintenance/Renovation; and
    - vii. Transportation.
2. Group II
- a. Assistance; and
  - b. Information
- B. The Aging Taxonomy contains the activity or service definitions of these services along with unit definitions.

**3.8.7 Reasons for Discharge from FCSP**

The following are reasons for service discharge:

- A. Death of caregiver or care recipient;
- B. Caregiver or care recipient moved out of service area;
- C. Caregiver or care recipient whereabouts is unknown;
- D. Caregiver chose to terminate services;
- E. FCSP service is a one-time service or item; or
- F. Program or service ended or terminated due to funding change.