KANSAS DEPARTMENT ON AGING
FIELD SERVICES MANUAL

TABLE OF CONTENTS

SECTION 1: INTRODUCTION AND GENERAL INFORMATION

1.1 General Definitions

1.2 Reserved

1.3 Grievances/Notices of Action/Appeals/Affirmative Action

1.3.1 Authorities (as amended)
1.3.2 Definitions
1.3.3 Grievance Procedure Requirements (OAA only)
1.3.4 Customer Rights and Responsibilities (All programs)
1.3.5 Notice of Action Requirements (All programs)
1.3.6 Appeals
1.3.7 Affirmative Action

1.4 Background Checks on Individuals Providing Services in the Home

1.4.1 Background Checks: Potential Employees and Individual Subcontractors
1.4.2 Documentation

1.5 Aging Taxonomy

1.6 Medicaid Provider Overpayment

1.6.1 Overpayment Identification
1.6.2 Referrals to Surveillance and Utilization Review Subsystem (SURS) and the Medicaid Fraud Unit

1.1 General Definitions

These are generic definitions. There may be slight variances across programs. Please consult program requirements and service definitions for further clarification.

Accrual Basis of Accounting: An accounting method in which revenues and expenses are identified with specific periods of time, such as a month or year, and are recorded when they are earned or incurred without regard to the date of receipt or payment of cash; distinguished from cash basis, modified cash basis, and modified accrual basis.

Activities of Daily Living (ADLs): Personal functional activities required by an individual for continued well-being and essential for health and safety which consist of eating, bathing, dressing, toileting, transfer, and mobility.

Adequate Proportion: A minimum proportion of Title III-B funds allocated to each area agency on aging (AAA) and designated by the State to carry out services associated with access services, in-home services, and legal assistance.

Administrative Requirements: The general practices that are common to the administration of grants, such as financial accountability, reporting, equipment management, and retention of records.

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, and adult day care facility, all of which classifications of adult care homes are required to be licensed by the Secretary of Aging (KSA 39-923 as amended).

Adult Day Care: Any place or facility operating less than 24 hours a day caring for individuals not related within the third degree of relationship to the operator or owner by blood or marriage and who, due to functional impairment need supervision of or assistance with activities of daily living (KAR 39-923).

Advance Payment: A payment made to a recipient either upon its request before cash disbursements are made by the recipient or through the use of predetermined payment schedules.

Allocable Cost: A cost that is allocable to a particular cost objective (i.e. specific function, grant project, service, department, or other activity) in accordance with relative benefits received. A cost is allocable to a federal award where it is treated consistently with other costs incurred for the same purpose in like circumstances and (1) is incurred specifically for the award; (2) benefits both the award and other work and can be distributed in reasonable proportion to the benefits received; or (3) is necessary for the overall operation of the organization.

Allowable Cost: A cost incurred by a recipient that meets all of the following requirements:

1. Reasonable for the performance of the award;
2. Allocable;

3. In conformance with any limitations or exclusions set forth in the federal cost principles applicable to the organization incurring the cost or in the Notification of Grant Award (NGA) as to the type or amount of cost;
4. Consistent with regulations, policies, and procedures of the recipient that are applied uniformly to both federally supported and other activities of the organization;
5. Accorded consistent treatment as a direct or indirect cost;
6. Determined in accordance with generally accepted accounting principles; and
7. Cost is not included in any other federally supported award (unless specifically authorized by statute).

Approved Budget: The financial expenditure plan for a grant-supported project, program, or activity, including revisions approved by the Kansas Department on Aging (KDOA). The approved budget consists of grant funds and recipient participation in the form of matching and non-matching funds. Expenditures under an approved budget that consists of both federal and non-federal shares are deemed to be borne by the recipient in the same proportion as the percentage of federal/non-federal participation in the approved budget.

Area Agency on Aging (AAA): The agency or organization within a planning and service area (PSA) that has been designated by the Secretary to develop, implement and administer a plan for the delivery of a comprehensive and coordinated system of services to older persons in the PSA. If AAA is used in conjunction with CME (AAA/CME), it denotes policy that relates to all programs.

Area Plan: The document developed by each AAA which describes the comprehensive and coordinated system of services to be provided to older persons in a PSA.

Assisted Living Facility: Any place or facility caring for six or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, by choice or due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes apartments for residents and provides or coordinates a range of services including personal care or supervised nursing care available 24 hours a day, seven days a week for the support of resident independence. The provision of skilled nursing procedures to a resident in an assisted living facility is not prohibited by this act. Generally, the skilled services provided in an assisted living facility shall be provided on an intermittent or limited term basis, or if limited in scope, a regular basis (KSA 39-923 as amended). Assisted Living Facilities have kitchenettes and private baths in each apartment.

Audit Resolution: The process of resolving audit findings, including those related to management and systems deficiencies and monetary findings (i.e., questioned costs).

Award: The document that obligates funds to a recipient to carry out an approved program or project (based on an approved application or progress report). The term, when used as a noun, is sometimes used interchangeably with “grant.”

Boarding Care Home: Any place or facility operating 24 hours a day, seven days a week, caring for not more than 10 individuals not related within the third degree of relationship to the operator or owner by blood or marriage and who, due to functional impairment, need supervision of activities of daily living but who are ambulatory and essentially capable of managing their own care and affairs (KSA 39-923 as amended).

Budget Category: A grouping of services under Title III-B Access, In-Home, and Community, or Title III-E Services or a line item under Titles III C(1), C(2), D, and E, excluding Supplemental Services. Senior Care Act line items are Attendant Care, Homemaker, and Case Management; the remaining services are categorized under "Other."

Budget Periods: The intervals of time (usually 12 months each) into which a project period is divided for budgetary and funding purposes. Funding of individual budget periods sometimes is referred to as "incremental funding."

Capital Outlay: An article of tangible non-expendable real or personal property that has a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

Caregiver: An adult family member, or another individual 18 or older, who is an informal provider of in-home and community care to another individual.

Carryover: See "Unearned OAA Funds."

Case Management Entity (CME): An entity or organization enrolled with the Medicaid fiscal agent to provide targeted case management services. If AAA is used in conjunction with CME (AAA/CME), it denotes policy that relates to all programs.

Cash Basis of Accounting: An accounting method in which revenue and expenses are recorded on the books of account when received and paid, respectively, without regard to the period in which they are earned or incurred; distinguished from accrual basis, modified accrual basis, and modified cash basis.

Cash Contribution: The recipient's cash outlay, including the outlay of money contributed to the recipient by third parties.

Cash on Hand: The amount of actual federal and state cash received to date from the awarding agency, less the cumulative amount of federal and state fund disbursements as of the reporting period end date.

Client Assessment, Referral and Evaluation (CARE): Kansas state law requires that "each individual prior to admission to a nursing facility as a resident of the facility shall receive assessment and referral services." To achieve this, the 1994 Kansas Legislature created the CARE (Client Assessment, Referral and Evaluation) program "for data collection and individual

assessment and referral to community-based services and appropriate placement in nursing facilities."

Client Assessment, Referral and Evaluation (CARE) Level I Assessment Form: The assessment tool completed on all individuals seeking placement in a Medicaid certified nursing facility. The assessment explains community-based alternatives, and collects data regarding unmet service needs. A CARE assessor trained by KDOA must complete the assessment.

Comprehensive and Coordinated Service Delivery System: A system for providing all necessary supportive service including nutrition services in a manner which:

1. Facilitates accessibility to, and utilization of, all supportive services and nutrition services provided within the geographic area served by such system by any public or private agency or organization; and
2. Develops and makes the most effective and efficient use of supportive services and nutrition services in meeting the needs of older persons.

Conservator: An individual or corporation appointed by a court whose duties are to manage the assets and obligations on behalf of the person (KSA 59-3051et seq. as amended).

Consultant: An individual who provides professional advice or services for a fee, but normally not as an employee of the engaging party. The term "consultant" also includes a firm that provides paid professional advice or services.

Contract: A promise or set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty.

Contract Under a Grant: A written agreement between a recipient and a third party to acquire commercial goods or services.

Contractor: One who is a party to a contract.

Contribution: Money or vision card units that are given by a customer, to pay for a portion of or total cost of service(s) received, to a provider that receives direct or indirect funds from KDOA.

Cost Center: Administrative categories of expenditures, including Personnel, Travel, Capital Outlay, Other Equipment, and Contractual.

Cost sharing: Any situation in which the recipient shares in the costs of a project other than as statutorily required matching. This includes situations in which contributions are voluntarily proposed by an applicant and accepted by KDOA by inclusion in the approved budget as shown in the NGA. Cost sharing must apply to certain services and be implemented statewide. (See Older Americans Act (OAA) Section 315(a) and FSM Section 3.6.5.F)

Customer: Any individual that requests or receives services, information, or assistance from KDOA, its contractors, or grantees.

Department: The Kansas Department on Aging (KDOA), created by KSA 75-5903 et seq., as amended.

Digital Signature: A type of electronic signature consisting of a transformation of an electronic message using an asymmetric crypto system such that a person having the initial message and the signer's public key can accurately determine whether 1) the transformation was created using the private key that corresponds to the signer's public key; and 2) the initial message has not been altered since the transformation was made.

Direct Costs: Costs that can be identified specifically with a particular sponsored project, an instructional activity, or any other institutional activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy.

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;
4. Mobility;
5. Self-direction;
6. Capacity for independent living;
7. Economic self-sufficiency;
8. Cognitive functioning; or
9. Emotional adjustment.

This definition shall not apply to the phrases: severe disability, developmental disabilities, physical or mental disability, physical and mental disabilities, or physical disabilities.

Disbursements: The sum of actual cash payments for direct charges for goods and services, the amount of indirect expenses charged to the award, and the amount of cash advances and payments made to subgrantees and contractors.

Donation: Money, or real or personal property given by a non-participant to a provider that is receiving direct or indirect funds from KDOA.

Durable Power of Attorney: A written document which states the document is a durable power of attorney and states, in substance, that the authority of the agent does **not** terminate in the event the principal becomes disabled, or in the event of later uncertainty as to whether the principal is dead or alive, and which complies with KSA 58-651 and KSA 58-652(a), as amended. (See "Power of Attorney" and "Durable Power of Attorney for Health Care Decisions.")

Durable Power of Attorney for Health Care Decisions: A written advance health care directive authorizing the named agent or agents to make health care decisions for the signer. This document contains the words "this power of attorney for health care decisions shall become effective upon the disability or incapacity of the principal" or words showing similar intent. The directive remains in force even if the signer becomes incapacitated. (KSA 58-632 as amended) (See "Power of Attorney" and "Durable Power of Attorney.")

Electronic Signature: An electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

End-stage Illness: In a physician's clinical judgment, an individual with any end-stage illness has six or less months to live. This judgment should be substantiated by a well-documented disease diagnosis and deteriorating clinical course.

Entity Identification Number: The 9-character Internal Revenue Service tax identification number (TIN) for organizations.

Equipment: Tangible, nonexpendable personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. The definition is applicable to all programs funded by or through KDOA.

Expenditures or Outlays: The charges made to the federal or state-sponsored project or program reported on an accrual basis.

Family: One or more adults and any minor children related by blood or law and residing in the same household. Emancipated minors and children living under the care of individuals not legally responsible for that care shall be considered one-person families. Where adults, other than spouses, reside together, each will be considered a separate family.

Final Financial Report: A contractor or grantee-prepared document that contains an accurate and complete disclosure of the financial results of the contract, grant, subcontract, or subgrant.

Fiscal Agent: The agency with whom Kansas Health Policy Authority (KHPA) contracts to process all Medicaid provider claims for payment.

Functional Eligibility: A measurement of an individual's abilities, or level of assistance needed, to complete important self-care activities. Generally, this takes into consideration a person's ability to complete their Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), Cognition, and Risk Factors. The measurement is established using a thorough assessment process and is used to determine the need and eligibility for a variety of services and programs.

Grant: A financial assistance support mechanism providing money, property or other direct assistance in lieu of money, or both, to an eligible entity to carry out an approved project or activity in support of a public purpose and not the direct benefit of the government.

Grantee: Any legal entity to which a grant is awarded and which is accountable to KDOA for the use of the funds received. The grantee is the entire legal entity even if only a particular component of the entity is designated in the grant.

Grantor: The Kansas Department on Aging or other entity that awards a grant.

Grant-supported Project or Activity: Those activities specified or described in an application or in a subsequent submission that are approved by KDOA for funding, regardless of whether federal or state funding constitutes all or only a portion of the financial support necessary to carry them out.

Greatest Economic Need: The need resulting from an income level at or below the poverty threshold established by the U.S. Department of Health and Human Services.

Greatest Social Need: The need caused by non-economic factors, which include physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status that 1) restricts the ability of an individual to perform normal daily tasks, or 2) threatens the capacity of the individual to live independently.

Grievance: A complaint, either written or oral, by an individual denied OAA services or expressing dissatisfaction with OAA service delivery or the quality of care.

Guardian: An individual or corporation appointed by the court to act on behalf of the individual and to provide for their care, treatment, habilitation, education, support and maintenance. For a guardian to be appointed, the court must find that the ward (the person for whom a guardian is appointed) is an adult person whose ability to receive and evaluate relevant information, or to effectively communicate decisions, is impaired such that the person lacks the capacity to meet essential requirements for such person's physical health, safety, or welfare (KSA 59-3051(a) and (e) and KSA 59-3075, as amended).

Home and Community Based Services/Frail Elderly (HCBS/FE): The HCBS/FE Waiver Program is an exception to the Medicaid State Plan that allows the State to provide home and community based services to customers who are at risk of entering a nursing facility.

Home Health Services: Any of the following services provided at the residence of the customer on a full-time, part-time or intermittent basis: Nursing, physical therapy, speech therapy, nutritional or dietetic counseling, occupational therapy, respiratory therapy, home health aide, attendant care services or medical social service (KSA 65-5101 (c) as amended).

Home Plus: Any residence or facility caring for not more than eight individuals not related within the third degree of relationship to the operator or owner by blood or marriage unless the

resident in need of care is approved for placement by the Secretary of the Department of Social and Rehabilitation Services, and who, due to functional impairment, needs personal care and may need supervised nursing care to compensate for activities of daily living limitations. The level of care provided residents shall be determined by preparation of the staff and rules and regulations developed by KDOA (KSA 39-923 as amended).

Indian Tribal Organization: The recognized governing body of any Indian tribe, or any legally established organization of Indians which is controlled, sanctioned, or chartered by the governing body of an Indian tribe.

Indirect Costs: Costs that are incurred by a grantee for common or joint objectives and cannot be identified specifically with a particular project or program. These costs are also known as "facilities and administrative costs."

Instrumental Activities of Daily Living (IADLs): Medical and/or functional aspects of daily living which would lead to significant health and safety risk unless services are provided, which consist of meal preparation, shopping, medication monitoring/treatments, laundry/housekeeping, money management, telephone, and transportation.

Kansas Aging Management Information System (KAMIS): The official electronic repository of data about KDOA's customers and the services they receive. KAMIS data includes the community-based services planned and provided to customers who do not enter nursing facilities. This customer-based data is used by KDOA and service providers to coordinate activity, reimburse providers for services rendered, and manage Aging programs.

Kansas Resident: An individual who resides in, rents, or owns property in Kansas (KSA 75-5928(a) as amended).

Level of Care: A measurement of the functional needs of the customer, as determined through an assessment or reassessment, based on impairment, in ADLs, IADLs, Cognition, and Risk Factors.

Licensed Health Professional: A physician, physician assistant, nurse practitioner, professional nurse, practical nurse, or social worker, functioning in accordance with the practice parameters for that profession.

Local Government: Any county, city, township, school district, or other political subdivision of the state, or any agency, bureau, office, or department thereof; or any Indian tribal organization. The term does not include institutions of higher education and hospitals.

Long Term Care Threshold: Means the level of care criteria, as established by the state and approved in the waiver to the Medicaid State Plan for HCBS/FE to determine eligibility for Medicaid Long Term Care Programs, which include the Nursing Facility program, HCBS/FE, and PACE. It is also utilized for certain services provided through the Senior Care Act program.

Maintenance of Effort (MOE): A federal Title III requirement established for non-federal expenditures. If non-federal expenditures for Title III programs spent for both services and administration are less than the three previous fiscal year average, the state's allotments for supportive and nutrition services under Title III will be reduced by a percentage equal to the percentage by which the state reduces its expenditures.

Match: Refers to a statutorily specified percentage of non-federal participation in allowable program or project costs that must be contributed by a recipient in order to earn federal or state funding, or a not-to-exceed percentage of federal participation.

Medical Care Provider: Means a physician, a physician assistant (PA), or an advanced registered nurse practitioner (ARNP).

Modified Accrual Basis of Accounting: Revenues are recognized in the period in which they become available and measurable, and expenditures are recognized at the time a liability is incurred pursuant to appropriation authority.

Modified Cash Basis of Accounting: May be the same as the modified accrual basis of accounting, or may be an accounting system under which revenues are recognized on a cash basis and expenditures are recognized on an accrual basis.

Monitoring: A process in which a grant's programmatic performance and business management performance are assessed by reviewing information gathered from various required reports, audits, site visits, and other sources.

Multipurpose Senior Center: A community facility for the organization and provision of a broad spectrum of services for older persons including health, mental health, social, nutritional, educational services and recreational activities.

Non-Federal Share: That portion of allowable project costs not borne by the federal government.

Notice of Action (NOA): Written notification to a customer, provider, or other authorized person of an action taken or to be taken.

Notification of Grant Award (NGA): The document that KDOA issues to the grantee, awarding financial assistance for the purchase of services and specifying the terms of the grant.

Obligation: The amounts of orders placed, contracts and subawards, goods and services received, and similar transactions during the grant period that will require payment during the same budget period or within 75 days following the last day of the project period.

Older Americans Act (OAA): The Act, passed in 1965, was the first federal program to focus on community-based services for older persons. The OAA is a federal formula grant program with specific services and activities for persons aged 60 and older. The OAA approach is based

on service provision, rather than on income support or vouchers. The OAA operates on a contribution basis. The OAA provides assistance through grants to state and AAAs for development and delivery of a coordinated system for persons 60 and older. Persons under the age of 60 may be eligible for specific services under the Act.

Planning and Service Area (PSA): A geographic area of the state designated by KDOA for the purpose of planning, development, delivery and overall administration of services under an area plan.

Power of Attorney: A written document whereby one person, as principal, gives legal authority to another to act as agent and perform certain specified acts or kinds of acts on behalf of the principal. The document may be effective immediately when executed or at a specified future date or upon the occurrence of a specified condition. The agent is attorney in fact whose power is revoked on the date of termination specified in the document or on the date when the agent acquires actual knowledge of the death of the principal or that the authority granted in the document has been suspended, modified, or terminated. Such power may be either general (full) or special (limited). Agents must keep records of receipts, disbursements, and transactions and may not comingle the principal's funds or assets with their own (KSA 58-650 et seq., as amended). (See "Durable Power of Attorney" and "Durable Power of Attorney for Health Care Decisions.")

Prior Approval: Written consent or issuance of an award by KDOA in response to a written request from the grantee to incur costs or take other action that requires such approval. If the costs or other actions are specifically identified in an application, approval of the application and issuance of an award based thereon constitutes such authorization.

Program for All-Inclusive Care for the Elderly (PACE): PACE integrates medical and long term care services for the frail elderly. Enrollees must be at least 55 years old, live in the catchment area of the PACE program, and be assessed to meet the eligible level of care established in the Medicaid State Plan. The goal of PACE is to maximize each enrollee's autonomy and continued residence in the community and to provide quality care at a lower cost to Medicare and Medicaid relative to their payments in the traditional system.

Program Income: Gross income earned by a grantee or contractor that is directly generated by the project, program, or activity, or earned as a result of the award during the project period. Voluntary contributions received from customers who wish to contribute to the cost of the service is a form of program income. Interest earned on advances of federal funds is not program income.

Program or Project Costs: The total allowable costs incurred by a grantee (and the value of third party in-kind contributions) in accomplishing the objectives of the award during the project period.

Project Period: The total time for which support of a project has been programmatically approved. A project may be approved for a multi-year period, but generally is funded in annual increments known as "budget periods."

Reasonable Cost: A cost whose nature or amount does not exceed that which would be incurred by a prudent person under the circumstances prevailing when the decision was made to incur the cost.

Recipient: The organization that receives a grant or contract from KDOA and is responsible and accountable for the use of the funds provided and for the performance of the grant or contract-supported project or activity. The recipient is the entire legal entity even if a particular component is designated in the NGA or contract.

Redesignation: A change in the geographic boundaries of a PSA or selection of an entity as a AAA that is different from the area previously designated for a particular PSA.

Reimbursement: A payment made to a grantee or contractor upon its request after it makes cash disbursements.

Residential Health Care Facility: Any place or facility caring for six or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, by choice or due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes individual living units and provides or coordinates personal care or supervised nursing care available on a 24 hour, seven day a week basis for the support of resident independence. The provision of skilled nursing procedures to a resident in a residential health care facility is not prohibited by this act. Generally, the skilled services provided in a residential health care facility shall be provided on an intermittent or limited term basis, or if limited in scope, a regular basis (KSA 39-923 as amended). Residential Health Care apartments do not have kitchenettes and may have shared bathing units.

Risk Factor: Factors that put an individual's health and welfare at risk to include: falls; neglect, abuse, and/or exploitation experienced; lack of informal support; and behavior.

Senior Care Act Program (SCA): Provides in-home services to customers age 60 or older that meet the functional need criteria. Services vary by county and are limited by budget constraints. The customer's co-pay is established on a sliding fee scale based on the customer's liquid assets and federal poverty guidelines. The customer's co-pay may be up to 100% of the cost of services.

Service Category: A line item or a group of line items. Under Title III-B, the grouped categories are Access, In-Home, Legal, and Other. Under Title III-E, the grouped category is Supplemental Services. The remaining Title III-B, III-E, and all Title III-C and III-D services are individual line items.

Significant Change In Condition in Relation to Community Based Services and the Uniform Assessment Instrument Process: A change in the customer's status that impacts the scoring of two (2) or more ADLs, IADLs, and/or Risk Factors including cognition, and results in a change to the plan of care. For Senior Care Act, this may also include a change in family status.

Subaward: Financial assistance in the form of money or property in lieu of money provided under an award by a grantee to an eligible subrecipient (or by an eligible subrecipient to a lower-tier subrecipient). The term includes financial assistance when provided by any legal agreement even if the agreement is called a contract, but does not include procurement of goods or services.

Subgrantee: Any legal entity to which a subgrant is awarded and that is accountable to the grantee for the use of the grant funds.

Subrecipient: An entity that receives a subaward from a grantee or another subrecipient under an award of financial assistance and is accountable to the grantee or other subrecipient for the use of the federal and state funds provided by the subaward.

Terms and Conditions of Award: All legal requirements imposed on a grant by KDOA, whether based on federal or state statute, regulation, policy, or other document referenced in the NGA, or specified by the NGA itself. In addition to general terms and conditions, the NGA may include other conditions that are considered necessary to attain the award's objectives, facilitate post-award administration, conserve grant funds, or otherwise protect the federal and state governments' interests.

Third-party: A party involved in the program or project, including volunteers, that is not a principal party to the grant or contract. Board members and staff, regardless of their duty status, are not considered third-party.

Third party In-kind Contributions: The value of non-cash contributions provided by non-Federal third parties. Third party in-kind contributions may be in the form of real property, equipment, supplies and other expendable property, and the value of goods and services directly benefiting and specifically identifiable to the project or program.

Total Program or Project Costs: The total allowable costs (both direct and indirect) incurred by the grantee to carry out a grant-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the grantee to satisfy a matching requirement.

Unallowable Cost: A cost specified by law or regulation, federal cost principles, or term and condition of award that may not be reimbursed under a grant or contract.

Unawarded Funds: Funds that have been allocated using the interstate funding formula but have not been awarded on a Notification of Grant Award (NGA).

Unearned OAA Funds (Carryover): Those funds that have been awarded to a grantee either that have not been expended by the grantee or that have been expended for unallowable costs due to the grantee's failure to comply with specific regulations, policies, or grant conditions governing the award or expenditures with insufficient match. (See Sections 7.1.6 and 8.1.6.E)

Uniform Assessment Instrument (UAI): An assessment instrument used for in-home service programs administered by KDOA.

Unliquidated Obligations: The amount of obligations incurred by the grantee or contractor that has not been paid. Expenses incurred that have not yet been paid as of the reporting period end date (cash basis) or expenses that have been incurred but not yet recorded (accrual basis). (Federal Register (FR) 69244 dated 12/7/07)

Unobligated Balance: The portion of funds authorized by KDOA that has not been obligated by the grantee.

Vision Card: A debit card given to eligible food assistance (formerly food stamp program) recipients for the purchase of food at groceries and other food vendors based on the amount of benefits the individual is eligible to receive.

Voluntary Contributions: Customer donations received for services provided with OAA funding, wherein the opportunity to contribute to the cost of the service was provided to each individual who received services under the OAA and the method of solicitation was non-coercive and confidential.

Volunteer Services: Unpaid services provided to a grantee or subgrantee by individuals, which are valued at rates consistent with those ordinarily paid for similar work in the grantee's or subgrantee's organization. If the grantee or subgrantee does not have employees performing similar work, the rates will be consistent with those ordinarily paid by other employers for similar work in the same labor market. In either case, a reasonable amount for fringe benefits may be included in the valuation.

Withholding of Payment: An action taken by KDOA, after appropriate administrative procedures have been followed, that restricts a grantee's ability to access its grant funds until the recipient takes corrective action required by KDOA.

Section 1.2

This section has been reserved..

1.3 Grievances / Notices of Action / Appeals / Affirmative Action

1.3.1 Authorities (as amended)

- For Medicaid Programs, KSA 77-601 et seq., 75-3304, 75-3306, and 75-5945 and KAR 30-7-65, 30-7-66, 30-7-67, and 30-7-68;
- For Older Americans Act (OAA) 306(a)(10) and 307(a)(5), KSA 77-601 et seq. and 75-5908, and KAR 26-4-1 et seq.; and
- For State Funded Programs KSA 77-601 et seq. and 75-5908, and KAR 26-4-1 et seq.

1.3.2 Definitions

Customer: Any individual that requests or receives services, information, or assistance from the Kansas Department on Aging (KDOA), an Area Agency on Aging (AAA)/Case Management Entity (CME), or contracted providers.

Notice of Action (NOA) (KDOA 904 form): Written notification to a customer, provider, or other authorized person of an action taken or to be taken.

Adequate NOA: An NOA that is sent prior to the action occurring.

Timely NOA: An NOA that is sent at least ten (10) clear calendar days before the effective date of an adverse action.

- Clear days means neither the effective date of action nor the mailing date shall be considered in determining the ten-day period.
- For example: an NOA that closes the case effective on the first day of the following month shall be mailed no later than the 20th of the month in 31 day months or the 19th of the month in 30 day months to be considered timely.

1.3.3 Grievance Procedure Requirements (OAA only)

A. Each AAA shall establish a written grievance procedure for customers who are dissatisfied with or denied OAA services.

B. During the initial implementation of OAA services provided in the home, the customer or his or her representative must receive the AAA's written grievance procedure.

C. Congregate meal providers are not required to give a copy of the grievance procedure to each customer. The written grievance procedure shall be posted in clear view for all customers.

D. Legal services providers shall provide the written grievance procedure upon initial contact with the customer.

1.3.3 (cont.)

E. Transportation providers shall provide the written grievance procedure before or upon the customer's initial use of transportation services.

F. Once the AAA has made a determination regarding the grievance, the AAA must send an NOA to the customer in accordance with subsection 1.3.5.

1.3.4 Customer Rights and Responsibilities (All programs)

A. The customer Rights and Responsibilities form (SS-12) shall be included with each NOA.

B. All customers or their representatives shall be provided the Rights and Responsibilities form (SS-12) when the following occur:

1. The applicant's initial determination or redetermination of eligibility for services provided in the home has been made;

2. The applicant or customer is sent an NOA; or

3. The applicant or customer has inquired about his or her rights and responsibilities.

C. State General Fund (SGF) and OAA service providers shall also provide the Rights and Responsibilities form (SS-012) to customers in the following circumstances:

1. Congregate meal providers shall make the form available to the customer upon request;

2. Home delivered meals providers shall provide the form before or upon the delivery of the customer's first home delivered meal;

3. Legal services providers shall provide the form upon initial contact with the customer; or

4. Transportation providers shall provide the form before or upon the customer's initial use of transportation services.

1.3.5 Notice of Action Requirements (All programs)

A. The originator of the NOA shall send a copy of the NOA and the Rights and Responsibilities form (SS-12) to the customer, his or her legal representative (if any), and all providers affected by the change. A copy of the NOA shall be maintained as part of the customer's case file.

1.3.5 (cont.)

B. **Required Elements**

1. For all programs, NOAs sent to customers shall contain, at a minimum, the following information:

   a. The customer's name;
   b. A description of the action to be taken;
   c. The effective date of the action;
   d. The citation(s) of the rule, policy, or statute upon which the action is based;
   e. The date the notice was sent;
   f. A note of who is copied on the NOA; and
   g. The customer Rights and Responsibilities form (SS-12), which contains information regarding the right to appeal the decision, shall be included with the NOA.

2. For the Home and Community Based Services for the Frail Elderly (HCBS/FE) program, NOAs sent to customers shall also contain the following:

   a. The customer's Medicaid identification (ID) number;
   b. The Targeted Case Manager's (TCM's) name, address, and telephone number;
   c. All waivered services, with details, for initial eligibility determination and annual eligibility redetermination (e.g., hours per day, hours per week, etc.);
   d. The affected waivered services when plan of care (POC) updates occur; and
   e. The customer's client obligation (if applicable).

C. **Adverse Actions**

1. Adverse actions are actions the AAA/CME intends to take to discontinue, terminate, suspend, or reduce service. Adverse actions include, but are not limited to, the following:

   a. The applicant or customer is determined ineligible for the program he or she is requesting or receiving;
   b. The customer is denied a service;
   c. The customer will not receive the quantity of service units he or she has requested or previously received; or
   d. The customer's case will close.

2. Regardless of program funding type, a timely NOA (10 days) shall be sent when an adverse action is to be taken.

1.3.5 (cont.)

D. **Other Actions**

1. Under the following circumstances, Medicaid and/or State Funded customers shall be sent an adequate NOA for the following actions:

   a. The customer requests an action to be taken, and that request is noted on the NOA implementing that action. If the action is adverse:

      i. implement the service change to begin on the date the customer specifies; and
      ii. change the Kansas Aging Management Information System (KAMIS) POC with an effective date 10 working days after the implementation date;

   b. The customer is determined eligible for the program he or she is requesting or receiving;
   c. The customer has a permanent change in case manager; or
   d. The customer's services are being implemented, changed, or other service-related changes have occurred which are not adverse and are reflected on the POC (i.e., change in service units, service transfers to another provider, county, or program, client obligation, etc.).

2. Upon receiving notice that a customer's service(s) has been interrupted for hospitalization, admission to a nursing facility, or any other reason that the customer is not available to receive services, the AAA/CME shall send an NOA, with start and end dates. If the end date is not known at the time of the initial NOA, a second NOA must be sent to reinstate services.

3. Upon receiving notice of the customer's death, the AAA/CME shall send an NOA to the customer's legal representative and providers that the customer's case is being closed.

4. If an OAA customer files a grievance with the AAA regarding OAA services for an action other than those adverse actions in Section 1.3.5.C, and the AAA has made a determination regarding the grievance, an adequate NOA shall be sent by the AAA informing the customer of the determination.

5. Failure by the AAA/CME to notify a provider of a customer's change in status may result in an overpayment and subsequent recoupment to that provider.

6. A POC shall be authorized in KAMIS or an effective dating request verified prior to the NOA being sent. If the CME authorizes services without appropriate authorization from KDOA, the CME will be responsible for payment to the provider(s) for services rendered prior to the KDOA approval date.

1.3.6 Appeals

A. Right to a Fair Hearing

A customer has the right to a fair hearing if he or she disagrees with an action or decision regarding his or her case. The customer Rights and Responsibilities form (SS-12) contains the customer's right to appeal and additional appeal information.

B. Continuation of Assistance for Medicaid Customers (excerpts from KAR 30-7-66)

1. If the customer requests a hearing within 10 days of the NOA mailing, services shall not be suspended, reduced, discontinued, or terminated, (but are subject to recovery by the agency if its action is sustained), until an initial decision of the hearing officer is rendered in the matter, unless:

    a. The request for a fair hearing concerns a discontinued program or service;

    b. A determination is made by the hearing officer that the sole issue is one of federal or state law, regulation or policy, or change in federal or state law, regulation or policy and not one of incorrect grant computation; or

    c. A change affecting the customer's assistance occurs while the hearing decision is pending and the customer fails to request a hearing after notice of the change.

2. The originator of the NOA shall promptly inform the customer, in writing, if service is to be continued or discontinued pending the hearing decision.

3. In any case where action was taken without timely notice, if the customer requests a hearing within ten (10) days of the NOA mailing, and the agency determines that the action resulted from other than the application of federal or state law or policy or a change in federal or state law, assistance shall be reinstated and continued until a decision is rendered in the matter except as set forth in (1) (a), (b), or (c), above.

C. Continuation of Assistance for State General Funded Programs

If the customer requests a hearing within ten (10) days of the NOA mailing, services shall not be suspended, reduced, discontinued, or terminated, (but are subject to recovery by the agency if its action is sustained), until an initial decision of the hearing officer is rendered in the matter, unless it is a situation involving immediate danger to the public's health, safety, or welfare (see KAR 26-4-1(b)(2)).

D. KDOA and the AAA/CME/Contracted Provider shall have separate roles during the appeal process.

1. KDOA's Role:

1.3.6.D.1 (cont.)

a. KDOA shall be responsible for presenting the case in initial defense of the action being appealed.

b. KDOA shall prepare the Appeal Summary, and shall, in all respects, represent the contractor during the appeal.

2. AAA/CME/Contracted Provider Role:

a. The AAA/CME/Contracted Provider shall fully cooperate and assist KDOA in such defense, and participate in the appeal process as needed.

b. The AAA/CME/Contracted Provider shall provide in a timely manner to KDOA access to any witnesses and/or documents pertinent to the case in order to help KDOA prepare for and defend the appeal.

c. A component of case management is to assist the customer with the appeal process, as requested.

d. The AAA/CME/Contracted Provider is not prohibited from explaining how a customer may seek review of a program decision or from providing an appropriate form for the customer to use in requesting a hearing.

e. During the hearing, the customer may be represented by any person or attorney as long as the representative is not the AAA/CME/Contracted Provider.

3. Appeals Above the Administrative Level:

a. To the extent permitted by law, the AAA/CME/Contracted Provider shall retain the right to appeal, pursuant to KAR Article 26-4 and the Kansas Act for Judicial Review and Civil Enforcement of Agency Actions (KSA 77-601 et seq., as amended), any final order or decision rendered at the administrative agency level which adversely affects the AAA/CME/Contracted Provider's interests and which KDOA decides not to appeal.

b. The AAA/CME/Contracted Provider shall be responsible for presenting its own case on appeal and KDOA shall be responsible for assisting the AAA/CME/Contracted Provider by providing copies of documents for use at the District Court level, and, if the District Court orders additional discovery, by making employees available to testify as witnesses.

c. KDOA has the right to take whatever action is necessary to protect its interests while the AAA/CME/Contracted Provider makes its appeal.

1.3.7 Affirmative Action

Organizations receiving funds from KDOA must follow the letter and spirit of the Kansas Act Against Discrimination of 1953, the Americans With Disabilities Act of 1990, the Civil Rights Act of 1964 and the Rehabilitation Act of 1973, as amended. Organizations must have written policies for the above Acts adopted by a formal action of their governing body that are available for their employees and the public.

1.4 Background Checks on Individuals Providing Services in the Home

1.4.1 Background Checks: Potential Employees and Individual Subcontractors

A. Questioning Applicants, Proposed Individual Subcontractors, and Applicants with Subcontractor Organizations.

1. Each Area Agency on Aging (AAA), and each organization proposing to contract or subgrant with a AAA to perform in-home services under the Older Americans Act or the Senior Care Act, shall require disclosure of each employee's criminal conviction (misdemeanor and felony) history to the employer, contractor, or subgrantee.

2. Each AAA subcontractor shall require each organization with which it contracts or subgrants for in-home services to require disclosure from each applicant for employment with the organization about the applicant's criminal conviction (misdemeanor and felony) history to the potential employer, contractor, or subgrantee.

3. Each AAA/Case Management Entity (CME) proposing to contract or subcontract with an individual to provide services in the home under the Older Americans Act, the Senior Care Act, the CARE Program, or Targeted Case Management shall require disclosure from each applicant about their criminal conviction (misdemeanor and felony) history to the potential employer, contractor, or subgrantee.

B. Checking References of Applicants, Proposed Individual Subcontractors, and Applicants with Subcontractor Organizations.

1. Each AAA, and each organization proposing to contract or subgrant with a AAA to perform in-home services under the Older Americans Act or the Senior Care Act, shall require and verify the personal and employment references of each applicant for employment.

2. Each AAA subcontractor shall require organizations with which it contracts or subgrants for in-home services to require and verify the personal and employment references of each applicant for employment with the organization.

3. Each AAA/CME proposing to contract or subcontract with an individual to provide services in the home under the Older Americans Act, the Senior Care Act, the CARE Program, or Targeted Case Management shall require and verify the personal and employment references of each applicant for employment.

1.4.1 (cont.)

C. Additional Background Checks of Applicants and Proposed Subcontractors.

1. Each AAA, and each organization proposing to subcontract or subgrant with the AAA, may perform any other additional investigation or background check of any applicant who proposes to contract or subgrant with them for the safety and security of its customers.

2. Each AAA/CME that deems it necessary for the safety and security of the customers may require additional investigation or background check of the applicant.

1.4.2 Documentation

A. Each AAA/CME and AAA/CME contractor, subcontractor, or subgrantee shall be required to maintain the following documentation for each individual providing services in the home:

1. Criminal conviction history affidavit or other sworn statements;
2. Documentation of applicant interview questions and responses; and
3. Personal and employment reference documentation, including the names of the individuals contacted, the method(s) of contact, the date(s), and information obtained.

B. Documentation shall be maintained by the AAA/CME or the AAA/CME contractor, subcontractor, or subgrantee for a period of five years after the last day on which employment or the contract, subcontract, or subgrant ends.

1.5 Aging Taxonomy

Area Agencies, Case Management Entities, service providers, and KDOA direct contractors must use the current Aging Taxonomy, which includes service/activity definitions, codes, units of service, funding sources, and those services that count toward adequate proportion. The current Aging Taxonomy is available by accessing the Information Memorandums (IMs). The Taxonomy is used to complete the Uniform Assessment Instrument, Abbreviated Uniform Assessment Instrument, the Uniform Program Registration, the Caregiver Assessment Plan, and Area Plan development.

1.6 Medicaid Provider Overpayment

1.6.1 Overpayment Identification

Upon identification of an overpayment made to an HCBS/FE Waiver Service Provider, or to a AAA for Targeted Case Management services, the following will occur.

A. Notification shall be sent under the signature of the Administrator of the Medicaid Quality Review Program to the Medicaid Provider Agency identifying the overpayment issue. The notification shall include:

1. The option of an informal review,
2. The provider's appeal rights, and
3. The method of recoupment that shall be used.

B. The Provider Agency has the option to request an informal review. Requests for an informal review shall be made within 10 working days of the initial letter requesting recoupment. The Informal Review Committee shall meet within 5 working days to review the documentation with the Provider Agency and render a decision.

All requests for an informal review, along with supporting documentation, shall be sent via facsimile to the Administrator of the Medicaid Quality Review Program who will chair the Informal Review Committee. The Committee will be comprised of the Medicaid Quality Reviewer who identified the overpayment, the appropriate MQR Regional Manager and the Administrator of the MQR program.

There are four possible outcomes of an informal review.

1. Evidence presented by the Provider Agency is sufficient to prove that no overpayment was made, and the issue is resolved at which time KDOA will issue a formal withdrawal letter.

2. Evidence presented by the Provider Agency is insufficient to prove that no overpayment was made. The Provider Agency either agrees to recoupment or proceeds with filing of a formal appeal.

3. Evidence presented by the Provider Agency is sufficient to prove that a portion of the overpayment was not made and is insufficient to prove that all of overpayment was not made. The Provider Agency either agrees to recoupment or proceeds with filing of a formal appeal.

4. If the Provider agrees to recoupment, the recoupment shall be made electronically by the Administrative Services Commission. If the Provider files a formal appeal, the Provider shall follow the established appeals policy.

C. If the Provider agrees to recoupment, a formal letter, outlining the agreement of the Provider Agency and the amount of the recoupment, shall be issued by the Administrator of the MQR program.

D. If the Provider files a formal appeal, the normal appeals process, as identified in Section 1.3 of the Field Services Manual, shall be followed. Appeals will be forwarded Kansas Department of Administration, Office of Administrative Hearings.

E. If the Provider Agency does not request an informal review or formal appeal within the allotted 30 days, the Provider Agency will be notified in writing by the Administrator of the MQR program that the recoupment shall be processed.

F. All efforts at recoupment shall be made by KDOA Administrative Services.

G. Adjustments shall be made electronically by KDOA.

H. Provider Agencies shall be notified, in writing, that the adjustment has been processed.

1.6.2 Referrals to Surveillance and Utilization Review Subsystem (SURS) and the Medicaid Fraud Unit

A. KDOA has the option to refer to SURS any overpayment issues which indicate a more extensive review is needed.

B. KDOA has the obligation to report suspected cases of Medicaid Fraud to the Medicaid Fraud and Abuse Division of the Kansas Office of Attorney General.

TABLE OF CONTENTS

SECTION 2: INTAKE, ASSESSMENT, AND REGISTRATION REQUIREMENTS

2.1 CARE Program

2.1.1 CARE Program Purpose
2.1.2 CARE Program Definitions
2.1.3 CARE Level I Assessor Qualification Requirements
2.1.4 CARE Level I Assessment Requirements
2.1.5 Appeal of Level I Assessment
2.1.6 CARE Level II Assessment Requirements
2.1.7 Proof of PASRR

2.2 Revoked

2.3 Revoked

2.4 Standard Intake Process

2.4.1 Purpose
2.4.2 Requirements

2.5 Uniform Program Registration Process

2.5.1 Purpose
2.5.2 Uniform Program Registration (UPR) Requirements

2.6 Uniform Assessment Instrument and Abbreviated Uniform Assessment Instrument Process

2.6.1 Purpose
2.6.2 Uniform Assessment Instrument (UAI) and Abbreviated Uniform Assessment Instrument (AUAI) Requirements

2.7 AUAI and UPR Trainer, UAI and AUAI Assessors, and UPR Interviewer Requirements

2.7.1 Purpose
2.7.2 UAI, AUAI, and UPR Trainer Requirements
2.7.3 UAI Assessor, AUAI Assessor, and UPR Interviewer Requirements

2.1.1 CARE Program Purpose

The purposes of the Client Assessment, Referral, and Evaluation (CARE) Program is for data collection, individual assessment, referral to community based services, and appropriate placement in long-term care facilities (K.S.A 39-968).

In order to be compliant with Section 1919(e)(7) of the Social Security Act, all individuals admitting to a Medicaid-certified nursing home need to have a valid proof of PASRR (pre-admission screening and resident review). The federal regulations for PASRR are located at 42 CFR Sections 483.100 through 483.138. The purpose of PASRR is to determine whether an individual with mental illness, mental retardation, or other developmental disability needs nursing facility services, or specialized mental health or mental retardation services.

In Kansas, the PASRR assessment is the CARE assessment. Prior to the individual's admittance to a Medicaid-certified nursing facility, the CARE assessment must be completed or the individual must possess a valid proof of PASRR. The exceptions to this rule are referred to as provisional admissions (See Section 2.1.4 G).

The CARE pre-admission assessment is formally called a Level I assessment. A Level I assessment will collect the same information regardless of who completes the CARE assessment. Nursing facility assessors may not conduct full CARE Level I assessments. If an admission is considered provisional or an emergency, a nursing facility assessor may complete the first two sections of the CARE assessment. The KDADS contracted assessor will complete the full CARE assessment when a resident is admitted to the NF without proof of PASRR.

The Level I assessment identifies the need for Level II screening. Unless the individual is identified as needing Level II screening, the Level I assessment will not restrict an individual's admission to a nursing facility; however, it may affect whether Medicaid or other entities will participate in payment for that care.

2.1.2 CARE Program Definitions

Intellectual Disability: A condition previously referred to as "mental retardation" or a variation of this term, and shall have the same meaning with respect to programs, or qualifications for programs, for individuals with such a condition.

Intermediate care facility for the mentally retarded: Any place or facility operating 24 hours a day, seven days a week caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to the functional impairments caused by mental retardation or a related condition, needs services to compensate for activities of daily living limitations. (KSA 39-923).

Significant Change in Condition for CARE Level I: A change in the individual's scores for two or more Activities of Daily Living (ADL) and /or two or more Instrumental Activities of Daily Living (IADL's) and/or Cognition Factors and/or Risk Factors.

Significant Change in Condition for CARE Level II: A change in the individuals' s cognitive abilities and/or social adaptive functioning as determined by a psychological assessment that documents either a significant gain or loss in cognitive abilities and/or social adaptive function, or a change in the individuals' physical health which results in a major decline or improvement in the functional status of the resident which is unexplained by the use of medication, an acute illness, infection, or injury.

2.1.3 CARE Level I Assessor Qualifications

A. An assessor shall be one of the following:

1. An employee of the KDADS CARE Level I contractor who is designated as an assessor (including sub-contractors and independent contractors);

2. An employee that is designated by a hospital, such as a discharge planner, social worker or registered nurse (RN); or

3. An employee of KDADS, or;

4. An employee that is designated by an NF or LTCU such as a social worker or RN (See Section 2.1.4.G for further information).

5. In the rare event of no available NF assessor the Director of Nursing shall complete the sections A and B, place the page in the resident medical record and forward to KDADS Level I contractor a request for a complete Level I assessment until a trained assessor may become available to the NF.

B. Assessor Experience and Education Requirements

1. The KDADS Level I contractor (including sub-contractors and independent contractors) must verify experience, education and certification requirements and maintain those records for five (5) years following termination of employment;

2. Each CARE assessor shall meet one of the following education requirements:

a.Four-year degree from an accredited college or university with a major in one of the following fields: gerontology, nursing, health, social work, counseling, human development and family studies, or related area as defined by KDADS; or

b.Licensed to practice in Kansas as a Registered Nurse.

C. Assessors must attend all Kansas Department for Aging and Disability Services (KDADS) required trainings for CARE assessors and participate in all state-mandated trainings to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by KDADS.

1. KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all CARE assessors. KDADS shall make available training materials and written documentation of successful completion of training.

2. Assessors must maintain a thorough and current knowledge of the community-based service system in their area. Verification of this effort may be requested at the discretion the KDADS CARE Manager.

3. Each assessor that has not conducted a CARE assessment within the last year must repeat the training and certification requirements for CARE Level I assessment.

4. KDADS Level I contractor (including sub-contractors and independent contractors shall maintain a list of their employed, qualified CARE assessors in KAMIS.

5. KDADS will maintain a current list of all qualified hospital and NF assessors.

2.1.4 Level I Assessment Requirements

A. When is a Level I Assessment Required?

1. All individuals 16 or older, regardless of race, national origin, color, sex, disability, or religion, who are seeking entry to a Medicaid-certified nursing facility or long-term care unit, shall be assessed with a CARE assessment by a qualified CARE assessor, unless the individual has a valid proof of PASRR (see Section 2.1.7 for valid proofs of PASRR).

In Kansas, individuals under the age of 16 may not be admitted to a nursing facility or long-term care unit.

2.If an individual in the community has had a previous CARE assessment and is now considering nursing facility care, a new CARE assessment is required if the initial CARE assessment indicates one or more of the following:

a. It is over 365 days old; or
b. a significant change of condition has occurred

B. When is a Level I Assessment <u>NOT</u> required:

3.When an individual is entering **a non-Medicaid certified** nursing facility or l ong- term care unit, or a nursing facility or long-term care unit conducted by and forthe adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing;

When the individual is not seeking admission to an NF or LTCU, they would not require a CARE assessment. He or she should be referred and/or assessed under the appropriate community based program.

4.When an individual's stay is expected to be **30 days or less**, and the individual has a written physician's certification stating the nursing facility stay is expected to be 30 days or less (Note: see Section 2.1.3.G regarding provisional admissions);

5.When an individual is **transferred to a swing bed** in a hospital;

6.When an individual is transferred to a long-term care unit of the **hospital that is not licensed as a skilled unit and is not Medicaid certified**; or

7.When an individual who resides in a nursing facility or long-term care unit has had a **CARE assessment performed within 365 days prior to admission with no significant change in condition**. CARE assessments and other proofs of PASRR are valid indefinitely for the individuals that continue to reside in the nursing facility or move between nursing home/hospital settings without a return for more than 30 days to the community.

8.When an individual has been **diagnosed with one of the following conditions**, and the diagnosis is based upon information documented in the individual's medical record and maintained by a hospital, nursing facility or physician's office:

a.Terminal illness, as defined in the 42 Code of Federal Regulations (CFR's) 418.3 as necessary to qualify for hospice services, which includes a medical prognosis of a life expectancy of six months or less; or

b.Coma or persistent vegetative state.

Under both (a) and (b) above, documentation must be sent to KDADS CARE staff for processing and generation of a categorical determination, which shall be maintained in the customer's clinical record with the supporting documentation as PROOF of PASRR.

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C. Level I Assessment Standards

1.Assessments shall be completed by qualified CARE assessors.

2.Assessments shall be completed within five working days from the date of referral. Assessment date shall be recorded on the assessment. If this time frame cannot be met due to weather, unexpected hospitalization, or need for family or legal guardian participation, the assessor shall contact KDADS CARE Program Manager and request approval of the exception. KDADS will approve or deny the request and make note of the request.

3.Assessments shall be conducted so that the individual understands the questions and can answer them accurately. All KDADS contractors must make arrangements for additional languages or interpreters, assistive devices, and provisions to adhere to the Americans with Disability Act.

4.The assessment shall be scheduled in such a manner that the individual is afforded the opportunity for family members, guardians, and other types of primary caregivers to provide input so that complete and accurate information is obtained regarding the individual's functional status and abilities.

5.Assessments shall be:

a. Completed according to the CARE Program Level I Training Manual;
b. Accurate; mistakes shall be struck through, corrected on the inside column of the form, initialed and dated by the assessor;
c. Legible; and
d. Written in black ink for copying and faxing purposes.

6.All CARE Level I assessment certificates and releases of information must be signed by the individual or their legal representative. Any assessment with an unsigned certificate is not a valid assessment.

(In the RARE instance that an individual is unable to sign and/or no legal representative able to be contacted for signature this situation should be discussed with KDADS CARE Program Manager and information regarding the circumstances should be included in the comments section of the assessment and entered into KAMIS.)

7.When a Level II referral is required, the assessor must:

obtain a copy of the legal guardianship papers, if applicable, with the guardian's name, mailing address, and phone number documented in the Contact Person section of the assessment;

b.obtain a copy of the individual's History and Physical (H & P), when available; and

c.document the following in the Comment sections of the assessment:

I. the individual's mental illness (MI) diagnosis, level of impairment,treatment history; and the dates and location of hospitalizations within the last two years, and any other supportive services the individual received and who provided them; or

II. the individual's mental retardation/developmental disability (MR/DD) diagnosis, date of diagnosis, and IQ score, if applicable; or

III. for individuals with a dual diagnosis of MI/MR/DD, the Comment sections should include information required in both (I) and (II) above.

8.The assessor must obtain the individual's or the legal guardian's signature, if applicable, on the Consent to Release Information form.

9.At the conclusion of the assessment, the assessor must provide the following information to the individual:

a.-copy of the CARE assessment,
b.the CARE certificate, and the Consent to
c.Authorization ofRelease Information for PHI;
d.An Explore Your Options guide (if applicable);
e.A CARE brochure
f.The assessing organization's privacy notice.

10. Within one working day, the assessor must fax the complete CARE assessment, CARE certificate, Consent to Release of Information (if signed), and other applicable, supporting information to KDADS. **Mailing this information is not acceptable.**

D. Within one working day, the CARE assessor shall make referrals to the following entities when necessary and appropriate:

1.An AAA/ADRC;
2.A Center for Independent Living; or
3.Other community-based service providers, such as Community Developmental Disability Organizations (CDDOs) and Community Mental Health Centers (CMHCs).If the individual has a legal guardian, the assessor shall notify the legal guardian in writing of the referral for a Level II assessment when a referral has been made.

E.Need for Further Assessment (Level II Referrals) Clearly Indicated.

All CARE Level I certificates issued with Section B (PASRR) marked as "YES" and

referred for a Level II assessment shall CLEARLY indicate the need for further assessment. A Level I assessment indicating *" referral for Level II"* and the Level I certificate not marked as *"indicated a need for further assessment*" is not a valid assessment and **must be corrected**. The corrected certificate and/or Level I must be submitted to the client and receiving nursing home and corrected in KAMIS.

F.Level I Assessments Conducted by Hospitals

1.When an individual is a patient in a medical care facility or hospital and seeks nursing facility admission, a CARE assessment may be completed as part of the discharge planning or other hospital discharge process.

2.Prior to completing a CARE assessment, hospital assessors must verify with theADRC whether the customer has a valid CARE assessment on file.

a.If the customer has a valid assessment and the customer has not experienced a significant change in condition (Section 2.1.3 (B)(2)(b)), a new CARE assessment should not be completed.

b.If a duplicate assessment is completed, the hospital CARE assessor is required to retrieve the CARE certificate that was issued with the duplicate assessment. The duplicate assessment and the CARE certificate will be considered void.

3.Hospital-based CARE assessors shall place original completed forms with customer's discharge planning papers, unless otherwise instructed by the hospital's records management.

4.Hospital assessors shall FAX a copy of the completed CARE Level I assessment, the Certificate and the Release of Information form along with any Level II referrals to KDADS CARE Program staff upon completion of the CARE Level I assessment for data entry into KAMIS. Both the hospital and KDADS must maintain a file on the CARE customer.

5.In the event of a lost CARE certificate, KDADS shall supply the duplicate certificate for assessments completed by hospitals after January 1, 2013.

G. Level I Assessments Conducted in Nursing Facilities

Nursing facility assessors may **not** conduct full CARE Level I assessments. If an admission is considered "provisional" or "emergency", a nursing facility assessor must complete the first two sections of the CARE assessment or, if the nursing facility does not have a CARE assessor on staff, the Director of Nursing must complete these two
sections. The partial assessment and supporting documentation must be kept as part of the

individual's clinical record.

1.A provisional admission to a nursing facility is allowed when an individual admits with a physician-certified planned stay of less than 30 days. To qualify as a provisional admission, a stay of 30 days of less must be:

a.A physician-ordered immediate admission due to the individual's health condition or for the purposes of rehabilitation, and the anticipated length of stay in the nursing facility is 30 days or less. The nursing facility must obtain the 30-day or less physician's statement prior to admitting the customer; or

b. A physician-ordered stay for an individual who resides in the community who requests respite care for 30 days or less

ALL provisional admission information (Sections A and B of the CARE Level assessment and hospital discharging information indicating the less than 30 day order with physician signature) must be faxed to KDADS CARE Program staff. CMS requires the physician to issue and sign the provisional order physically or electronically. NF staff telephone orders or hospital discharge planning staff signatures are NOT able to be accepted.

If the individual's original intent is to stay 30 days or less and the individual discharges within 30 days, no other action is necessary.

If on day "20" it appears that the stay is going to exceed 30 days, the nursing facility staff shall contact the ADRC and arrange for the completion of a full CARE assessment.

2.Emergency admissions to nursing facilities are when an urgent condition or a situation occurs that places the individual's health and/or welfare in jeopardy.

A full CARE assessment is required **within the first seven days** after an individual is admitted to a nursing facility for an emergency. If a nursing facility admits an individual under one of the following emergency situations, **the nursing facility must contact the ADRC within one working day** and request a full CARE assessment:

a. An admission is requested by Department for Children and Families,(DCF) Adult Protective Services (APS);
b. A natural disaster occurs;
c. The primary caregiver becomes unavailable, due to a situation beyond the caregiver's control (e.g., caregiver becomes ill or an accident involving the caregiver occurs);
d. A physician ordered immediate admission due to the individual's condition; or e. an admission from an out-of-state community to a nursing facility that is beyond the

individual's control, i.e., an individual being admitted from their place of residence in another state on a weekend when an ADRC CARE assessor is not available.

The nursing facility assessor shall complete the first two sections of the CARE assessment, and fax the partial assessment with a copy of the Emergency Fax Memo to the ADRC **within one working day**. If there is an emergency not listed in this policy, contact KDADS CARE staff immediately for authorization of the emergency admission without proof of PASRR. http://www.aging.ks.gov/CARE/CARE_index.htm

3.In the event of a lost CARE certificate for assessments completed in the community or nursing home, the ADRC completing the assessment will provide the duplicate certificate.

2.1.5 Appeal of Level I Assessment

If the individual is referred for a Level II assessment as a result of a Level I CARE assessment, he or she shall be notified verbally, and in writing on the CARE certificate (KDOA 152), that he or she has the right to appeal the PASRR portion of the assessment.

2.1.6 CARE Level II Assessment Requirements

A. A CARE Level II assessment is required if the individual has a serious mental illness (MI), is mentally retarded/developmentally disabled (ID/DD), and/or has a related condition/other developmental disability (RC/ODD), and meets the conditions listed subsection 1 or 2 (below).

1.An individual with a serious mental illness shall meet all of the following conditions in subsection a, b, and c (below) to trigger a Level II assessment:

a.The individual must have a **clinical diagnosis** of one of the following mental illnesses:

- •295.10 Schizophrenia, Disorganized Type
- •295.20 Schizophrenia, Catatonic Type
- •295.30 Schizophrenia, Paranoid Type
- •295.60 Schizophrenia, Residual Type
- •295.90 Schizophrenia, Undifferentiated Type
- •295.70 Schizoaffective Disorder
- •296.23 Major Depressive Disorder, Single Episode, Severe, without Psychotic Features
- •296.24 Major Depressive Disorder, Single Episode, with Psychotic Features
- •296.32 Major Depressive Disorder, Recurrent, Moderate
- •296.33 Major Depressive Disorder, Recurrent, Severe, without Psychotic Features
- •296.34 Major Depressive Disorder, Recurrent, Severe, with Psychotic Features
- •296.35 Major Depressive Disorder, Recurrent, in Partial Remission
- •296.36 Major Depressive Disorder, Recurrent, in Full Remission
- •296.89 Bipolar II Disorder
- •296.xx All Bipolar I Disorders
- •297.10 Delusional Disorder
- •298.9 Psychotic Disorder NOS
- •300.21Panic Disorder with Agoraphobia
- •300.3 Obsessive-Compulsive Disorder
- •301.83Borderline Personality Disorder

b.**Level of Impairment**- The disorder results in functional limitations in major life activities **within the past three to six months** that would normally be appropriate for the individual's developmental stage. Typically, an individual has at least one of the characteristics in the following areas on a continuing or intermittent basis:

1.Interpersonal functioning- The individual has serious difficulty interacting appropriately and communicating effectively with other persons or a possible history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships or social isolation;

2.Concentration, persistence and pace- The individual has serious difficulty in sustaining focused attention for a long enough period
to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; or

3.Adaptation to change- The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

c.**Treatment history** indicates the individual has experienced at least one of the following:

1.Psychiatric treatment more intensive than outpatient care **more than one time in the past two years**; this care is limited to hospitalization for more than one day for the primary purpose of providing psychiatric treatment, or participation for more than one day in a program provided by a mental health entity who defines the program as a partial hospitalization psychiatric treatment program; this also includes hospitalization in a state hospital for two or more consecutive years, which qualifies as two inpatient hospitalizations; a hospitalization for less than two years is considered as one inpatient hospitalization; or

2.**Within the last two years, due to the mental disorder, the** individual experienced an episode of significant disruption to the normal living situation, which is defined as a period of time no less than one month in length during the past two years, during which the individual's mental illness affected them so profoundly that one or more of three following situations occurred.

a.**Supportive services** were required to maintain functioning
at home or in a residential treatment environment.

This may have occurred when, during that time period, the individual required a significant increase in services to assist with one or more of the following:

- Instrumental activities of daily living (i.e., shopping, meal preparation, laundry, basic housekeeping, money management, etc.);
- Basic health care (i.e., hygiene, grooming, nutrition, taking medications, etc.);
- Coping with symptoms of extreme withdrawal and social isolation, decreasing incidents of inappropriate social behavior (i.e., screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.); and
- Decreasing incidents of self -harming behavior.

Supportive services also include services provided in a correctional facility when the individual has a Mental Illness and/or a Mental Retardation diagnosis, has been housed in a separate Mental Health area for 30 or more consecutive days, during which he or she has been receiving mental health services from a masters level Mental Health Professional.

b.**Intervention by housing officials** occurred. Individuals that have been evicted from their homes or shelters for situations which include one or more of the following:

- Inappropriate social behavior, i.e., screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior; or
- Abuse or neglect of physical property, i.e., including: failure to maintain property as outlined in the lease, intentional destruction of property such as through kicking or hitting walls or doors.

(**Note**: nonpayment of rent, substance abuse, and other such situations can only be included in this category if a direct relationship between the activity and an increase in the severity of the mental illness can be shown.)

c.**Intervention by law enforcement officials** occurred. Individuals that have been arrested and/or taken into custody for one or more of the following:

- Harm to self, others, or property; inappropriate social behavior, i.e., screaming, verbal harassment of others, physical violence toward others, and/or inappropriate sexual behavior; or
- evidence of impairment so severe as to require monitoring for safety.

(**Note**: substance abuse can only be included in this category if a direct

relationship between the activity and an increase in the severity of the mental illness can be shown.)

d.**Intervention by Adult Protective Services** (APS) occurred. Intervention by Adult Protective Services can be said to have occurred when the individual has been determined by an APS worker to be a danger to self or others due to the severity of the mental illness. For example, the individual threatens harm to self or others, is not eating, exhibits extreme weight loss or is non-compliant with medications.

2.An individual who is mentally retarded or has an "other developmental disability"(ODD) shall have one of the following diagnoses to trigger a Level II assessment:

a.The individual has a level of retardation (mild, moderate, severe, or profound) described in the American Association on Mental Retardation's Manual (AAMRM) on classification in Mental Retardation (1983), meaning significantly sub-average intellectual functioning as evidenced by an IQ of 70 or below on a standardized measure of intelligence and has manifested itself before customer reached the age of 18; or

b.The individual has an ODD as defined by 42 CFR Section 435.1009. Persons with an ODD mean individuals who have a severe, chronic disability that meets all of the following conditions that are attributable to:

1.Cerebral palsy or epilepsy; or

2.Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

These conditions include but are not limited to: Autism, Spina Bifida, Down's Syndrome, or other similar physical and mental impairments (or conditions that have received a dual diagnosis of mental retardation and mental illness).

Note: The condition is not the result of a mental illness. There is an impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons.

3.The ODD shall meet the following conditions:

a.It is manifested before the person reaches age 22;

b.It is likely to continue indefinitely;

c.It results in substantial functional limitations in three or more of the following areas of major life activity:

i.Self-care, which is the performance of basic personal care activities;

ii.Understanding and use of language, which is receptive and expressive; communication involving both verbal and nonverbal behavior enabling the individual both to understand others and to express ideas and information to others;

iii.Learning, defined as general cognitive competence and ability to acquire new behaviors, perceptions and information, and to apply experiences in new situations;

iv.Mobility, which is the ability to move throughout one's residence and to access and utilize typical settings in one's community;

v.Self-direction, which is the management and taking control over one's social and personal life; ability to make decisions affecting and protecting one's own interests;

vi.Capacity for independent living, which is the ability to live safely without assistance from other persons; includes housekeeping, participation in leisure time activities, and use of community resources; or

vii.Economic self-sufficiency, which is the ability to pay for basic needs and services through employment or other financial resources.

B.Resident Reviews

A nursing facility is required to contact **KDADS** and order a resident review when an individual meets one or more of the following criteria:

1.The resident has had a significant change in condition that would have triggered a Level II assessment, or has had a significant change in condition resulting in a new mental illness diagnosis (as defined earlier in this Section) accompanied by a change in level of impairment (for example, a change in condition that requires more intensive care than medication adjustment for stabilization); OR

2.The resident met all the Level II criteria prior to entering the nursing facility but it was not uncovered until after admittance to the nursing facility. The criteria is outlined in Section 2.1.5 of the Field Services Manual and should include one of the following: mental illness diagnosis, level of impairment and/or treatment history; IQ score of 70 or

below; or a related condition; OR

3.The resident has a serious mental illness, mental retardation or other developmental disability and was admitted to the nursing facility prior to 1989; OR

4.The resident entered the nursing facility with a PASRR determination letter authorizing a short-term rehabilitation stay, and that stay will exceed the time frame in the letter.

Special Note: A Resident Review is not required when an individual improves and no longer needs the level of services provided in the nursing facility. It is expected the nursing facility will make arrangements for discharge back into the community, which may include contacting the appropriate Community Mental Health Center (CMHC) or Community Developmental Disability Organization (CDDO).

2.1.8 Proof of PASRR

A.Proof of PASRR differs from state to state. Since PASRR is a federal law, if a resident is transferring from out-of-state, prior to the admission, the nursing facility must contact KDADS to verify that all PASRR requirements have been met.

B.People admitted to nursing facilities prior to 1989 that continuously reside in a nursing facility since that time, are in effect "grand fathered" and do not require a CARE assessment or any proof of PASRR on file. However, if the "grand fathered" nursing facility resident has a diagnosis of serious Mental Illness or MR/DD, he or she should have a Level II letter on file with the nursing facility. If the individual does not have a Level II letter, the nursing facility should contact KDADS to verify that all PASRR requirements have been met.

C.In Kansas, there are five methods nursing facilities can utilize to establish evidence that PASRR requirements have been met. They are:

1.**SRS's form 2123 (January 1, 1989 - December 1992)**
Before any formal Kansas Preadmission Screening (PAS) program, SRS issued form 2123 to nursing facilities to indicate that Level I PASRR requirements were met.

2.**Kansas Foundation for Medical Care (KFMC) letter (January 1993 - June 1993)** The first preadmission screening was administered by KFMC. Persons assessed by KFMC were given a letter indicating that a Level I assessment had been completed. A copy of such a letter is a proof of PASRR.

3.**BOCK (July 1993 - December 1994)**
Administration of the Kansas preadmission screening (then called KPAR) program was transferred to Bock & Associates. Persons assessed under KPAR were provided a letter on either Bock & Associates or Bock & Associates/Dept. of SRS letterhead. The letter

is also considered proof of a Level I PASRR

4.**CARE Program (January 1995 - present)**

On January 1, 1995, the Kansas Department on Aging became responsible for administering the preadmission screening program through the CARE Program. Individuals seeking nursing facility placement in an Medicaid-certified Nursing Home must receive a CARE assessment and be provided with a CARE certificate as proof that a Level I CARE assessment has been conducted.

5.As of January 1, 2013 the **Kansas Department for Aging and Disabilities Services** (formerly KDOA) assumed responsibility for administering preadmission screening through the CARE Program utilizing a contracted entity to perform assessments.

This section has been revoked since the information incorporated into Section 2.1.

This section has been revoked.

2.4 Standard Intake Process

2.4.1 Purpose

The Standard Intake Information Form (SS-002) is an important tool used to achieve the standardization of intake information and to efficiently and effectively provide the most equitable system to customers.

2.4.2 Requirements

A. The Area Agency on Aging (AAA)/Case Management Entity (CME) and/or their designee must complete a Standard Intake Information Form for customers requesting any in-home, case management, or adult day care/health service(s), excluding home-delivered meals.

B. In the event that a waiting list exists for a service or program for which there is an assessment or registration requirement, AAA/CME staff and/or their designee must complete the intake and inform the customer about the existence of the waiting list.

C. When a AAA/CME designee completes a Standard Intake Information Form, the completed form must be submitted to the AAA/CME.

D. Each AAA/CME must maintain copies of all completed intakes for a period of five (5) years, including those intakes that do not result in assessments and those completed by a AAA/CME designee.

E. When the Standard Intake Information Form results in an assessment or registration, AAA/CME and provider staff must follow policy as outlined in Sections 2.5 and 2.6 regarding the completion requirements for assessments or registrations.

F. The interviewer must complete certain data fields of the Standard Intake Information Form. The required data fields are indicated by bolder type font on the form. The date the intake is considered complete is the date the required, bolded fields are completed.

G. AAAs/CMEs, service providers, and Kansas Department on Aging (KDOA) direct contractors must develop and implement a written policy and procedure to ensure non-duplication of customer assessment and registration.

H. The Standard Intake Information Form data must be entered into the KDOA designated management information system within ten (10) working days of the date the intake was completed.

I. As appropriate, the information on the Standard Intake Information Form may be made available to service providers in order to facilitate service delivery.

J. When an intake results in an assessment and subsequent service delivery, the AAA/CME must maintain the intake as a part of the customer's case file.

2.5 Uniform Program Registration Process

2.5.1 Purpose

The Uniform Program Registration form (UPR-001) is required to achieve consistency of data collection to efficiently and effectively determine eligibility and manage services and programs, to provide the most equitable system to customers, and to collect required data for funding source reporting.

2.5.2 Uniform Program Registration (UPR) Requirements

A. The UPR may be completed by the customer, either
   1. Individually, without assistance, or
   2. With face-to-face or telephone assistance from a UPR reviewer.

B. The AAA must develop and implement a written policy and procedure to ensure customers wanting to register for services specified in Sections 2.5.2.B and 2.5.2.C can easily access, complete and return the UPR, either in paper or electronic format (e.g., by facsimile or other electronic media), and/or by telephone.

C. As specified in Section 2.7.3, only persons who meet the qualifications, training and certification requirements may review the UPR.

D. The UPR must be completed and data entered into the state identified database system for the following services, listed with funding source(s):

   Congregate Meals
   - Older Americans Act (OAA) III C1

   Congregate Meal- Illness Related Home Delivered
   - OAA III C2

   Nutrition Counseling
   - OAA III C1 (for Congregate Meal customers)
   - OAA III D

   Assisted Transportation
   - OAA III B

E. Area Agencies on Aging (AAAs) and AAA contractors must develop and implement a written policy and procedure to ensure non-duplication of customer assessment and registration.

F. The UPR must be completed pursuant to the UPR Instruction Manual, including appendices and updates, available on the KDADS Provider Website.

2.5.2 (cont.)

G. If a laptop computer is used while completing a registration in a customer's home, the customer's electricity must not be used to power the computer unless approved by the customer. The customer's phone line may only be used if the cost is not charged to him or her.

H. Once determined eligible, the eligibility period is 365 days. Subsequently, a new UPR must be completed annually, and within 365 days of the previous UPR. The Kansas Department for Aging and Disability Services (KDADS) will not pay for meals or services that are provided to customers who have not been determined currently eligible for the program or service for which they have applied as specified in FSM Section 4.2.

I. To initiate the KDADS automated billing process each month, data entry of all required forms must be completed by the 24th of the month following the month services were provided.

2.6 Uniform Assessment Instrument and Abbreviated Uniform Assessment Instrument Process

2.6.1 Purpose

The Uniform Assessment Instrument (SS-005) and the Abbreviated Uniform Assessment Instrument (SS-003) are required to achieve consistency in the assessment process and data collection, to efficiently and effectively determine eligibility and manage services and programs, to provide the most equitable system to customers, and to collect required data for funding source reporting. Consult the Aging Taxonomy for the service definition of assessment and related funding sources.

2.6.2 Uniform Assessment Instrument (UAI) and Abbreviated Uniform Assessment Instrument (AUAI) Requirements

A. As specified in Section 2.7.3, only persons that are qualified, trained and certified may conduct the Full UAI or Abbreviated UAI.

B. Full UAI Requirements

1. The Full UAI is required for all services under the following funding sources and programs:

   a. Home and Community Based Services/ Frail Elderly Waiver (HCBS/FE)
   b. Senior Care Act (SCA)
   c. Expedited Service Delivery (ESD)

2. The Full UAI is required for the following services listed with funding source(s):

   a. Adult Day Care/Adult Day Health
      - Older Americans Act (OAA) III B

   b. Assessment
      - OAA III B
      - TCMSGF

   c. Attendant/Personal Care
      - OAA III B

   d. Case Management
      - TCM
      - OAA III B

   e. Homemaker
      - OAA III B

2.6.2 (cont.)

C. Abbreviated Uniform Assessment Instrument (AUAI) Requirements

An Abbreviated UAI is required for the following services listed with funding source:

1. Assessment
   - OAA III B
   - OAA III C2

2. Chore
   - OAA III B

3. Home Delivered Meals
   - OAA III C2

4. Nutrition Counseling (for Home-Delivered Meals customers)
   - OAA III C2

D. UAIs must be completed in accordance with the most current UAI Instruction Manual.

E. The most comprehensive assessment or registration required for the services must be used.

F. All programs, providers, and Area Agencies on Aging (AAAs)/Case Management Entities (CMEs) must accept other programs', providers', or AAAs'/CMEs' assessments, as long as each assessment meets the timeframe according to Section 2.6.2.L, and is complete and comprehensive enough to cover the service(s) provided.

G. AAAs/CMEs and service providers must develop and implement a written policy and procedure to ensure non-duplication of customer assessment and registration.

H. The assessment must be customer driven, and must not be conducted against the wishes of the customer.

I. If a customer refuses to participate in an assessment to the extent that his or her eligibility for a program or service cannot be determined and there is no designated person to act on the customer's behalf, he or she cannot receive services. (See program eligibility criteria.) The reason the customer refused to answer assessment questions must be documented in the comments section of the UAI.

J. If a laptop computer is used while conducting an assessment in a customer's home, the customer's electricity must not be used to power the computer unless approved by the customer. The customer's phone line may only be used if the cost is not charged to him or her.

2.6.2 (cont.)

K. The Kansas Department on Aging (KDOA) will not pay for meals or services that are provided to customers who have not been determined eligible for the program or service. A customer is considered eligible if he or she has had an assessment and has been found eligible for the program or service.

L. Timeframe Requirements:

1. The assessment must be completed within six (6) working days of the date the Standard Intake Information Form was completed or ES3160 received from the Kansas Department of Social and Rehabilitation Services (SRS), with the following exceptions:

   a. A waiting list exists for the services the customer requested and the customer is not interested in exploring other options;
   b. The customer or his/her family requests the assessment be postponed; or
   c. The customer cannot be reached, which is documented in the file.

2. For up to six (6) working days, a AAA or nutrition provider may opt to serve Home Delivered Meals to a person whose eligibility has not been determined on the Abbreviated UAI. KDOA will not pay or reimburse for home delivered meals that are provided to customers determined ineligible. The AAA or nutrition provider must ensure that OAA program-related funds are not used to provide services to ineligible persons, either prior to and/or after ineligibility has been determined on the Abbreviated Assessment.

3. Assessments are valid up to 365 days unless there has been a significant change. (See Section 1.1 for the significant change definition.) Instances that would allow the reassessment to be completed later than 365 days would include the following:

   a. Hospitalization and the customer is unable to participate in the assessment;
   b. Planned brief stay in a nursing facility; or
   c. Admitted to a rehabilitation facility.

   In these instances, the reassessment and data entry must be completed the week preceding discharge or no later than three (3) working days after discharge or notification that discharge has occurred.

4. To initiate the KDOA automated billing process each month, data entry of all required forms such as, but not limited to, UAIs, AUAIs, Uniform Program Registrations (UPRs), Caregiver Assessment Plans (CAPs) and plans of care (POCs), must be completed on or before:

   a. The 15th of the month for TCMSGF and ESD; and
   b. The 24th of the month for SCA and OAA funded services.

2.7 AUAI and UPR Trainer, UAI and AUAI Assessors, and UPR Interviewer Requirements

2.7.1 Purpose

In order to provide efficient and effective training and certification to all persons that complete training sessions on assessment and registration processes, the Kansas Department on Aging (KDOA) has established policies to govern persons designated by KDOA, the Area Agencies on Aging (AAAs), Case Management Entities (CMEs), and KDOA direct contractors to be Abbreviated Uniform Assessment Instrument (**A**UAI) and Uniform Program Registration (UPR) Trainers, Uniform Assessment Instrument (UAI) Assessors, AUAI Assessors, and UPR Interviewers.

2.7.2 UAI, AUAI, and UPR Trainer Requirements

A. KDOA shall have the responsibility for conducting all training sessions, certification, and recertification of all UAI Assessors. KDOA shall provide training materials and written documentation of successful completion of training.

B. KDOA shall have responsibility for conducting all training sessions, certification and recertification of all AUAI and UPR trainers. The AAA shall have responsibility for verification of trainer education, experience qualifications, and written documentation of training completion.

C. AUAI and UPR Trainers shall be one of the following:

1. An employee of a AAA;
2. An employee of a AAA provider that is designated as a potential trainer by the AAA;
3. An independent contractor that is designated as a potential trainer by the AAA; or
4. An employee of a KDOA direct contractor that is designated as a potential trainer by the contractor.

D. Experience and education qualifications of AUAI and UPR Trainer:

1. One year of experience as an AUAI assessor or UAI assessor; and
2. A high school diploma.

KDOA will not waive the educational requirements; however, a waiver of the experience requirement may be granted upon written request to the Secretary.

2.7.2 (cont.)

E. Trainers must attend initial and recertification training sessions that cover all assessment and registration forms. Recertification training sessions will be scheduled when changes or updates occur. There will not be any waivers of the training and certification requirements.

F. The following are the AUAI and UPR Trainer's responsibilities.

1. The trainer must adhere to all applicable policies which include:

   a. Standard Intake Information Form Requirements, Section 2.4;
   b. Uniform Program Registration (UPR) Requirements, Section 2.5;
   c. AUAI Requirements, Section 2.6; and
   d. AUAI Assessor and UPR Interviewer qualifications and certification requirements, Section 2.7.3.

2. Communicate and coordinate within the AAA to determine the need for training sessions on the AUAI and/or UPR.

3. Schedule and conduct both the initial and recertification training sessions as necessary. (See Section 2.7.3 for requirements regarding AUAI Assessor and UPR Interviewer initial and recertification training sessions.)

4. Include in each training session the forms, policies, procedures, and information necessary for the potential AUAI Assessor or UPR Interviewer to successfully complete their assessment or interview tasks.

G. In the event that KDOA, the AAA, or the KDOA direct contractor receives a complaint or determines the trainer fails to meet the policy requirements in Section 2.7.2, KDOA, the AAA, or the KDOA direct contractor will work with the trainer to resolve the issue.

H. In the event the trainer fails to meet policy requirements in a substantive manner or consistently fails to meet the policy requirements, KDOA may suspend or terminate the certification of any trainer. Notwithstanding the foregoing, the AAA or KDOA direct contractor who has hired the individual to provide training may reassign them, remove training from their job responsibilities, suspend or terminate the trainer from employment or the contract for training purposes. In the event any such action is a result of either a failure to meet policy requirements in a substantive manner or consistent failure to meet the policy requirements, the AAA or KDOA direct contractor shall notify KDOA of the entirety of the circumstances surrounding the action taken.

2.7.3 UAI Assessor, AUAI Assessor, and UPR Interviewer Requirements

A. Assessors and Interviewers shall be one of the following:

1. A KDOA employee;
2. An employee of a AAA/CME ;
3. An employee of a AAA provider that is designated as an assessor or interviewer by the AAA;
4. An independent contractor that is designated as an assessor or interviewer by the AAA/CME; or
5. An employee of a KDOA direct contractor that is designated as an assessor or interviewer by the contractor.

B. Experience and education requirements for Full UAI Assessors

1. One year of experience as defined by the AAA/CME or for KDOA staff, as defined by KDOA; and
2. Education requirements:
   a. Four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the AAA/CME; or
   b. A Registered Nurse licensed to practice in Kansas.
3. The AAA/CME must verify experience, education and certification requirements are met for assessors identified in 2.7.3.A.2-4. The AAA/CME must maintain these records for five (5) years following termination of employment.

C. Experience and education qualification requirements of Abbreviated UAI Assessors

1. One year of experience as defined by the AAA or KDOA direct contractor; and
2. At least a high school or general education diploma.
3. The AAA must verify experience, education and certification requirements are met for assessors identified in 2.7.3.A.2-4. The AAA must maintain these records for five (5) years following termination of employment.

2.7.3 (cont.)

D. Experience and education qualifications of a UPR Interviewer shall be defined by the AAA that employs or contracts with the interviewer.

The AAA must verify experience, education and certification requirements are met. The AAA must maintain these records for five (5) years following termination of employment.

E. Assessors and interviewers must attend initial certification and recertification training sessions that cover the form(s) the assessor or interviewer is being certified to complete. There will not be any waivers of the training and certification requirements.

F. An assessor or interviewer that has not conducted any assessments or interviews within the last six months must repeat the training and certification requirements for the assessment and/or registration he or she will use.

G. UAI and AUAI Assessors shall adhere to the requirements in Section 2.6.2. UPR Interviewers shall adhere to the requirements in Section 2.5.2.

1. In the event that KDOA, the AAA/CME, or the KDOA direct contractor receives a complaint or determines the assessor or interviewer fails to meet the policy requirements, KDOA, the AAA/CME, or the KDOA direct contractor will work with the assessor or interviewer to resolve the issue.

2. In the event that an assessor or interviewer consistently fails to meet policy requirements, KDOA, the AAA/CME, or the KDOA direct contractor who designated the assessor or interviewer may suspend or terminate his or her certification status.

TABLE OF CONTENTS

SECTION 3: COMMUNITY BASED SERVICES

3.1 Case Management Services

3.1.1 Introduction and Definition
3.1.2 Targeted Population
3.1.3 Customer Eligibility
3.1.4 Case Management Qualifications
3.1.5 Components of Case Management
3.1.6 Training and Certification Requirements
3.1.7 Skills Requirements
3.1.8 General Case Management Standards
3.1.9 Service Limitations
3.1.10 Billing
3.1.11 Case Manager Safety and Welfare
3.1.12 Reasons for Discharge from Case Management Services

3.2 Reserved

3.3 Reserved

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

3.4.1 HCBS/FE Services
3.4.2 HCBS/FE Rates

3.5 Home and Community Based Waiver – Frail Elderly (HCBS/FE)

3.5.1 Program Description and Purpose
3.5.2 Definitions
3.5.3 General Eligibility Guidelines
3.5.4 Procedure of Eligibility Determination and Implementation of Services
3.5.5 HCBS/FE Plan of Care
3.5.6 Cost Cap Exceptions
3.5.7 Interruption of Services
3.5.8 Supplementation of HCBS Services
3.5.9 Self-Directed Care Requirements
3.5.10 Transition from Other Waivers to HCBS/FE Waiver
3.5.11 Communication with the SRS Medicaid Eligibility Worker
3.5.12 Case Log and Documentation Requirements
3.5.13 Transfer of a Customer’s Case or KAMIS Person Administration
3.5.14 Case Closure for HCBS/FE
3.5.15 Closing an HCBS/FE File
3.5.16 HCBS/FE Quality Review Process

TABLE OF CONTENTS

SECTION 3: COMMUNITY BASED SERVICES
(Continued)

Appendix A HCBS/FE Forms
Appendix B Process for Billing HCBS/FE Assessments
Appendix C Expedited Services Delivery (ESD)
Appendix D Effective Dating Requests (EDR)
Appendix E Assistive Technology Authorization
Appendix F Plan of Care (POC) Approval Information
Appendix G HCBS/FE Waiting List
Appendix H Crisis Exception Process
Appendix I Customer Service Worksheet – Time Allowances

3.6 Senior Care Act

3.6.1 Program Description and Outcomes
3.6.2 Authorities (as amended)
3.6.3 Definitions
3.6.4 Eligibility Criteria
3.6.5 Service Provision
3.6.6 Self-Directed Attendant Care and Homemaker Services
3.6.7 Service Limitations
3.6.8 Compliance Standards
3.6.9 Program Administration
3.6.10 Service Discharge

3.7 Revoked

3.8 Family Caregiver Support Program

3.8.1 Program Description and Outcomes
3.8.2 Definitions
3.8.3 Eligibility
3.8.4 Program Requirements
3.8.5 Program and Service Limitations
3.8.6 Services
3.8.7 Reasons for Discharge from FCSP

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.

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

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
A. Assessment		
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. Development of a Plan of Care (POC)		
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

	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

Component	Senior Case Manager Qualification Required	Junior Case Manager Qualification Allowed
C. Referral and Related Activities		
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
D. Monitoring and Follow-up Activities		
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

Component	Senior Case Manager Qualification Required	Junior Case Manager Qualification Allowed
b) conducted as defined in Section 3.1.8.B to determine whether:		
• services are being furnished in accordance with the individual's POC;	Yes	No
• the services in the POC are adequate; and	Yes	No
• 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.	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

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.

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.

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.

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;

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.

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.

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.

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.

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.

3.4.1 (cont.)

C. ATTENDANT CARE SERVICES

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

PROVIDER DIRECTED ATTENDANT CARE SERVICES

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

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

Level I

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

3.4.1.C (cont.)

ENROLLMENT

For Service **A** only-

- Non-medical resident care facilities licensed by the Kansas Department of Social and Rehabilitation Services (SRS).
- Entities not licensed by SRS, KDOA or the Kansas Department of Health and Environment (KDHE) must provide the following:
    - a certified copy of its Articles of Incorporation or Articles of Organization. If a Corporation or Limited Liability Company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.
    - written proof of liability insurance or a surety bond.

For Service **A or B**-

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

3.4.1.C (cont.)

Level II
(An initial RN evaluation visit is necessary)

Service C	Service D
ADLs- physical assistance or total support • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services	Health Maintenance Activities • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance
	An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a Licensed Nurse.
	A certified Home Health Aide or Certified Nurse Aide shall not perform acts beyond the scope of their curriculum without delegation by a Licensed Nurse.

3.4.1.C (cont.)

Level III
(An initial RN evaluation visit is necessary)

ADLs- Supervision, physical assistance, or total support • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services	Health Maintenance Activities • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance
IADLs • Shopping • House cleaning • Meal preparation • Laundry • Medication setup, cuing and reminding	An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a Licensed Nurse.
	A certified Home Health Aide or Certified Nurse Aide shall not perform acts beyond the scope of their curriculum without delegation by a Licensed Nurse.

3.4.1.C (cont.)

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

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

Medication Administration Assistance in a Private Residence (KAR 28-51-108)

A KDHE Licensed or Medicare Certified Home Health Agency can provide nursing delegation to aides with sufficient training. The nurse delegation and training shall be specific to the particular customer and their health needs. The qualified nurse retains overall responsibility.

ENROLLMENT

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

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

For Level III Services

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

3.4.1.C (cont.)

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

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

Attendant Care is limited to a maximum of 48 units (12 hours) per day of any combination of Provider-directed Level I, Provider-directed Level II, and Self-directed.

Attendant Care is limited to a maximum of 48 units (12 hours) per day for Provider – directed Level III.

Transportation is not covered with this service, but if medically necessary, it may be covered through regular Medicaid.

A customer's spouse, guardian, conservator, person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a customer shall not be paid to provide Attendant Care for the customer. The only exception to this policy will be a relative who is an employee of an assisted living facility, residential health care facility, or home plus in which the customer resides and the relative's relationship is within the second degree of the customer. (See KAR 26-41-101 and KAR 26-42-101 for regulatory requirements.)

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

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

3.4.1.C (cont.)

SELF-DIRECTED ATTENDANT CARE SERVICES

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

IADLs	ADLs	
• Shopping • House cleaning • Meal preparation • Laundry • Medication setup, cuing or reminding, and treatments	• Bathing • Grooming • Dressing • Toileting	• Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services
HEALTH MAINTENANCE ACTIVITIES		
• Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition	• Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance	

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

According to KSA 65-1124(l), a customer who chooses to self-direct their care is not required to have their attendant care supervised by a nurse. Furthermore, KSA 65-6201(d) states that Health Maintenance Activities can be provided ". . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home." Health Maintenance Activities and Medication Setup must be authorized, in writing, by a physician or an RN (AKA licensed *professional* nurse).

3.4.1.C (cont.)

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

LIMITATIONS

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

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

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

> EXCEPTION TO THIS LIMITATION: Customers who were active on any HCBS waiver prior to July 1, 2000, and have had the same representative continually directing their care during that time, are exempt from this limitation. The TCM shall complete a home visit at least every three (3) months to ensure that the selected direct support worker is performing the necessary services.

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

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

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

3.4.1.C (cont.)

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

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

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

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

Attendant Care services are limited to a maximum of 48 units (12 hours) per day of any combination of Provider-directed Level I, Provider-directed Level II, and Self-directed.

Transportation is not covered with this service, but if medically necessary, it may be covered through regular Medicaid.

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

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

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

3.4.1 (cont.)

D. COMPREHENSIVE SUPPORT

DEFINITION

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

The support worker is present to supervise the customer and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example: read mail, books, and magazines or write letters) may also be provided.

Comprehensive Support is to be provided in the customer's choice of housing, including temporary arrangements.

This service shall not duplicate other waiver services.

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

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

LIMITATIONS

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

Support worker must be 18 years of age or older.

3.4.1.D (cont.)

Comprehensive Support is limited to a maximum of 48 units (12 hours) per day to occur during the customer's normal waking hours. Comprehensive Support in combination with other FE waiver services cannot exceed 24 hours per day.A customer who has a guardian and/or conservator cannot choose to self-direct his or her comprehensive support; however, a guardian and/or conservator can make that choice on the ward's behalf.

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

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

Customers residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care Home must have this service provided by a licensed home health agency and are not eligible to self-direct this service.

An individual providing Comprehensive Support must have a permanent residence separate and apart from the customer.

This service is limited to those customers who live alone or do not have a regular caretaker for extended periods of time.

Comprehensive Support cannot be provided at the same time as HCBS/FE Attendant Care Services or HCBS/FE Sleep Cycle Support.

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

<u>ENROLLMENT FOR PROVIDER-DIRECTED COMPREHENSIVE SUPPORT:</u>

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

3.4.1.D (cont.)

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

    1. A certified copy of its Articles of Incorporation or Articles of Organization. If a Corporation or Limited Liability Company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.

    2. Written proof of liability insurance or surety bond.

ENROLLMENT FOR SELF-DIRECTED COMPREHENSIVE SUPPORT:

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

3.4.1 (cont.)

E. FINANCIAL MANAGEMENT SERVICES

DEFINITION

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

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

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

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

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

3.4.1.E (cont.)

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

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

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

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

3.4.1.E (cont.)

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

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

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

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

LIMITATIONS

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

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

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

3.4.1.E (cont.)

ENROLLMENT

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

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

3.4.1.E (cont.)

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

3.4.1.E (cont.)

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

3.4.1 (cont.)

F. HOME TELEHEALTH

DEFINITION

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

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

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

Customers qualify for this service if the customer:

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

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

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

3.4.1F (cont.)

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

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

LIMITATIONS

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

Customer must have a landline or wireless connection.

Installation required within 10 working days of approval.

Maximum of two installations per calendar year.

Monthly status reports to the physician and case manager.

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

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

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

ENROLLMENT

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

3.4.1 (cont.)

G. MEDICATION REMINDER

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

This service does not duplicate other waiver services.

LIMITATIONS
Maintenance of rental equipment is the responsibility of the provider.

Repair/replacement of rental equipment is not covered.

Rental, but not purchase, of this service is covered.

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

These systems may be maintained on a monthly rental basis even if the customer is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.

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

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

3.4.1 (cont.)

H. NURSING EVALUATION VISIT

DEFINITION

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

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

LIMITATIONS

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

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

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

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

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

ENROLLMENT

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

3.4.1 (cont.)

I. ORAL HEALTH SERVICES

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

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

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

Services shall not include outpatient or inpatient facility care.

Orthodontic and implant services are not covered.

Complete or partial dentures are allowed once every 60 months.

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

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

3.4.1 (cont.)

J. PERSONAL EMERGENCY RESPONSE

DEFINITION

Diagnosis alone does not determine need for this service. The TCM authorizes the need for this service based on an underlying medical or functional impairment.

This service does not duplicate other waiver services.

Personal Emergency Response units are electronic devices and have portable buttons worn by the customer. These units provide 24 hour a day on-call support to the customer having a medical or emergency need that could become critical at anytime.

Examples include:

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

LIMITATIONS

Maintenance of rental equipment is the responsibility of the provider.

Repair/replacement of rental equipment is not covered.

Rental, but not purchase, of this service is covered.

Call lights do not meet this definition.

This service is limited to those customers who live alone, or who are alone a significant portion of the day in residential settings, and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
Once installed, these systems may be maintained on a monthly rental basis even if the customer is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.

Installation for each customer is limited to twice per calendar year.

ENROLLMENT

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

3.4.1 (cont.)

K. SLEEP CYCLE SUPPORT

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

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

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

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

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

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

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

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

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

3.4.1.K (cont.)

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

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

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

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

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

3.4.1 (cont.)

L. WELLNESS MONITORING

DEFINITION

This service provides a Wellness Monitoring visit through nursing assessment by a licensed nurse. This service provides an opportunity for the nurse to check a customer's health concerns that have been identified by the TCM. This service reduces the need for routine physician/health professional visits and care in more costly settings. Any changes in the health status of the customer during the visits are then brought to the attention of the TCM and the physician as needed. A written report must be sent to the TCM documenting the customer's status within two (2) weeks of the nurse visit.

This service includes:

- Nursing Diagnosis
- Nursing Treatment
- Counseling and Health Teaching
- Administration/Supervision of Nursing Process
- Teaching of the Nursing Process
- Execution of the Medical Regimen

This service shall not duplicate other waiver services.

LIMITATIONS

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

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

ENROLLMENT

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

3.4.2 HCBS/FE Rates

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

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.

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 15th 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;

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.

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 3rd, the case could remain open until September 30th). **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).

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.

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;

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:

3.5.13.A (cont.)

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:

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

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

Appendix B: Process for Billing HCBS/FE Assessments

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

- 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 15th 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 25th. Medicaid determination must be made by SRS before TCM billing may occur.
- Customer is determined not Medicaid eligible May 23rd
- 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 15th

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 10th to be effective May 1st;
- 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 2nd
- Customer applied to SRS on June 5th. 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

Appendix C: Expedited Services Delivery (ESD)

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)

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.

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.

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

Appendix D: Effective Dating Requests

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

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

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

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).

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.

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

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

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

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

SERVICE	Maximum Time Allowed	Reasons for Additional Time*
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

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.

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.

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 3rd, the case could remain open until September 30th).

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.

IADLs	ADLs	
• Shopping • House cleaning • Meal preparation • Laundry • Medication setup, cueing, or reminding and treatments • Life management (financial matters, i.e., bill paying)	• Bathing • Grooming • Dressing • Toileting	• Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services

HEALTH MAINTENANCE ACTIVITIES

- Monitoring vital signs
- Supervision and/or training of nursing procedures
- Ostomy care
- Catheter care
- Enteral nutrition
- Wound care
- Range of motion
- Reporting changes in functions or condition
- Medication administration and assistance

Customers or their representatives are given the option to self-direct their attendant care/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(l), a customer who chooses to self-direct their care is not required to have their attendant care supervised by a nurse. Furthermore, KSA 65-6201(d) states that Health Maintenance Activities can be provided ". . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home." Health Maintenance Activities and Medication Setup must be authorized, in writing, by a 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

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:

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;

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).

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:

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

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;

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 20th 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 20th 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 20th 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 20th and October 20th 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.

KANSAS DEPARTMENT ON AGING
FIELD SERVICES MANUAL

TABLE OF CONTENTS

SECTION 4: NUTRITION

4.1 Nutrition Services
(FS 2002-03; Effective: July 1, 2002)

4.1.1. Outcomes
4.1.2 Target Population
4.1.3 Program Definitions
(FS 2002-08; Effective: December 23, 2002)
4.1.4 USDA Food Assistance Programs
4.1.5 Nutrition Service Provider Requirements
4.1.6 Food Management
4.1.7 Menu Certification Criteria
4.1.8 Computer Nutrient Analysis Requirements
4.1.9 Meal Pattern Requirements
4.1.10 Special Menus including Modified Menus and Therapeutic Diets
4.1.11 Program Income
(FS 2002-08; Effective: December 23, 2002)
4.1.12 Catering
4.1.13 Vouchers

4.2 Congregate Nutrition Services
(FS 2002-03; Effective: July 1, 2002)

4.2.1 Eligibility Criteria
4.2.2. Congregate Nutrition Service Provider Requirements
4.2.3. Establishing, Relocating, or Closing of Congregate Settings

4.3 Home-Delivered Meals
(FS 2002-03; Effective: July 1, 2002)

4.3.1. Eligibility Criteria
4.3.2 Home-Delivered Meals Nutrition Service Providers Requirements

4.1 Nutrition Services

4.1.1 Purposes

A. The purposes of Nutrition Services administered by the Kansas Department for Aging and Disability Services are as follows:
   1. To reduce hunger and food insecurity;
   2. To promote socialization of older individuals; and
   3. To promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior. (OAA, Section 330)

4.1.2 Target Population

A. Nutrition services are targeted to people 60 years of age or older in greatest social and economic need, particularly low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. An additional target criterion of the home delivered nutrition services program is that program resources are targeted to those most in need of meals and at greatest nutritional risk. (OAA, Section 305 A1E)

4.1.3 Program Definitions

A. **Caretaker -** An individual 60 years of age or older who is a non-spousal family member or other individual, and is providing a service(s) free of charge to an eligible participant of home delivered nutrition services.

B. **Congregate Meal** - A meal provided to an eligible participant in a congregate setting.

C. **Congregate Setting -** A congregate nutrition center, non-traditional setting, or satellite meal site that complies with the Americans with Disabilities Act (ADA) and where two (2) or more people gather.

   1. **Congregate Nutrition Center -** This is a meal site, or facility licensed by the Kansas Department of Agriculture (KDA), in which a congregate nutrition service provider supplies a service.

   2. **Non-Traditional Setting -** This is a congregate setting such as a church or apartment building where pre-packaged meals are delivered and served. No licensure by KDA is required.

   3. **Satellite Meal Site -** A location licensed by KDA for the service of congregate or home delivered nutrition services. The food is prepared in a central kitchen and delivered in bulk to this location.

4.1.3 (cont.)

D. **Cost of the Meal -** The total projected cost of the congregate or home delivered meal program, less applicable costs for nutrition education and nutrition counseling, divided by the total projected number of meals to be served.

E. **Customer -** See General Program Definitions, Section 1.1.

F. **Department -** The Kansas Department for Aging and Disability Services (KDADS), created by KSA 75-5903 *et seq.* and any amendments thereto.

G. **Dietary Reference Intakes (DRI) -** A set of nutrient-based reference values established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences that include: Estimated Average Requirements (EARs), Recommended Dietary Allowances (RDAs), Adequate Intakes (AIs), and Tolerable Upper Intake Levels (ULs). They are based on scientifically grounded relationships between nutrient intakes and indicators of adequacy, as well as the prevention of chronic diseases, in apparently healthy populations.

H. **Dietary Supplement -** A product (other than tobacco) intended to supplement the diet that bears or contains one or more of the following ingredients: a vitamin; a mineral; an herb or other botanical; an amino acid; a dietary substance for use by man to supplement the diet by increasing the total dietary intake; or a concentrate, metabolite, constituent, extract, or combination of any of these ingredients. (FD&C 321.ff.1)

I. **Dietitian -** A professional who is registered with the Academy of Nutrition and Dietetics and/or licensed in the State of Kansas as a Dietitian.

J. **Eligible Participants -** Individuals who meet the eligibility criteria for the program.

K. **Food Code** – Food safety regulations that govern licensed food service establishments, retail food stores, and food vending companies. A copy of the current KDA Food Code (KAR 4-28-8 as amended) can be obtained from the KDA website.

L. **Food for Special Dietary Uses -** Means particular (as distinguished from general) uses of food, as follows:

1. Uses for supplying particular dietary needs which exist by reason of a physical, physiological, pathological or other condition, including but not limited to the conditions of diseases, convalescence, pregnancy, lactation, allergic hypersensitivity to food, underweight, and overweight; and

2. Uses for supplying particular dietary needs which exist by reason of age, including but not limited to the ages of infancy and childhood; and

4.1.3.L (cont.)

3. Uses for supplementing or fortifying the ordinary or usual diet with any vitamin, mineral, or other dietary property. Any such particular use of a food is a special dietary use, regardless of whether such food also purports to be or is represented for general use.

4. The use of an artificial sweetener in a food, except when specifically and solely used for achieving a physical characteristic in the food which cannot be achieved with sugar or other nutritive sweetener, shall be considered a use for regulation of the intake of calories and available carbohydrate, or for use in the diets of diabetics and is therefore a special dietary use (21CFR105.3)

M. **High Nutritional Risk -** An individual who scores six (6) or higher on the DETERMINE Your Nutritional Risk checklist published by the Nutrition Screening Initiative, which is reflected on the Department's UAI and AUAI as the Nutrition Risk Screen.

N. **Home Delivered Meal -** A meal provided to an eligible participant who resides in a non-institutional setting.

O. **Homebound -** The status of an individual that:

1. Is physically homebound and/or socially homebound; and

2. Is unable to prepare meals for himself or herself because of:

   a. Limited physical mobility; or

   b. A cognitive impairment; or

   c. Lacks the knowledge or skills to select and prepare nourishing and well-balanced meals; and

3. Lacks an informal support system such as family, friends, neighbors, or others who are willing and able to perform the service(s) needed, or the informal support system needs to be temporarily or permanently supplemented.

P. **Isolated -** Geographic isolation due primarily to an individual residing in a rural location that does not afford access to a congregate setting because:

1. A congregate setting is not located in the community; and

2. No transportation is available to a neighboring community with a congregate setting; or

3. The older individual is not able, or chooses not, to drive to a neighboring community with a congregate setting.

4.1.3.P (cont.)

a. The intent of this definition of isolated is to allow Area Agencies on Aging (AAAs) to serve those few older individuals who live in a rural setting and are not able to access congregate meals in a neighboring community. The definition is not intended to permit services in a community where a large number of older individuals choose, for whatever reason, not to participate in a nearby congregate setting.

b. NOTE: AAAs are encouraged to place greater emphasis on services to those older individuals who are homebound due to functional impairment (two or more Activities of Daily Living or Instrumental Activities of Daily Living) than on those who only meet the "isolation" eligibility criterion.

Q. **Mechanically Altered Diet** - A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

R. **Medical Food** - Food which is formulated to be consumed or administered enterally under supervision of a physician, and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

S. **Medical Nutrition Therapy (MNT)** - Nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional. MNT is a specific application of the Nutrition Care Process and Model in clinical settings that is focused on the management of disease. MNT involves in-depth individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease.

T. **Non-Eligible Participants** - Individuals who do not meet the eligibility criteria for the program.

U. **Nutrition Counseling** - Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietitian to address the options and methods for improving nutrition status.

V. **Nutrition Service Provider** - An agency or entity that is awarded Older Americans Act (OAA) Title III C to provide at least one hot or other appropriate meal per day, five or more days a week, and any additional meals that the recipient of an OAA grant or contract may elect to provide.

4.1.3 (cont.)

W. **Person in Charge -** The individual in charge of the licensed food establishment and present during all hours of operation. This person must demonstrate knowledge of food-borne disease prevention, application of the Hazard Analysis Critical Control Point (HACCP) principles, and the requirements of the Food Code. This knowledge must be demonstrated by compliance with the Food Code, or by having passed an approved food protection program (such as Serv-Safe), or by responding correctly to the KDA inspector's questions.

X. **Physically Homebound -** An individual who cannot leave his or her house under normal circumstances (i.e., without assistance) due to illness and/or incapacitating disability and is unable to participate in the congregate nutrition program.

Y. **Potentially Hazardous Food -** A food that requires time/temperature control for safety to limit pathogenic microorganism growth or toxin formation.

Z. **Pre-Packaged -** A program meal that is pre-portioned on plates, trays, or other single service containers at a KDA licensed facility for delivery to a non-traditional setting for immediate consumption.

AA. **Socially Homebound -** An individual who chooses not to receive meals at a congregate setting and, in the assessor's professional judgment, the individual is psychologically, emotionally, or socially impaired.

1. This category is for those few, isolated cases where the individual, due to one of the impairments listed above, is uncomfortable in the congregate setting and chooses not to receive nutrition services unless they are home delivered.

BB. **Take-out Meal -** A congregate meal the eligible participant removes from the congregate setting prior to consumption.

CC. **Therapeutic Diet -** A diet ordered by a physician to manage problematic health conditions of a specific individual. Therapeutic refers to the nutritional content of the food. Examples include calorie-specific, low-salt, low-fat, lactose free, and no added sugar.

DD. **Voucher -** A payment method for services provided under an agreement with appropriate eating establishments in the community, i.e., cafes and hospitals, grocery stores with in-store dining.

4.1.4 Nutrition Services Incentive Program (NSIP)

A. A meal is eligible for NSIP support if it:

1. Is served to an eligible participant;

4.1.4.A (cont.)

2. Meets the nutrition requirements prescribed by KDADS; and

3. Meets all remaining standards established for meals served under OAA Title III C.

B. Within 90 days of the last day of the report month, nutrition service providers that receive NSIP support must report adjustments that increase the number of meals served. However, adjustments that reflect decreases in NSIP support will be accepted beyond the 90-day period.

4.1.5 Nutrition Service Provider Requirements

A. AAAs must establish written procedures and assign staff to annually assess central nutrition project operations and individual congregate settings to determine whether nutrition service providers are meeting policies applicable to their programs. A copy of the assessment report including findings, recommendations, and corrective actions is to be sent to the provider within 60 calendar days after the assessment visit. KDADS has the right to access each provider and center, and the AAA assessment of the nutrition services provider, when it deems necessary.

B. Nutrition service providers must complete the appropriate form (see Sections 2.5 and 2.6) to determine eligibility, ensuring that individuals requesting services are eligible. KDADS will not reimburse for meals served to non-eligible participants.

C. Nutrition service providers must operate efficiently and effectively. “Efficiently” refers to the relative total cost of providing a unit of service. “Effectively” refers to the capacity to provide a defined service as intended by the OAA, which includes service quality, quantity, and timeliness that meet the intent of the OAA.

D. Nutrition service providers must utilize appropriate paid and/or volunteer staff to assure satisfactory fiscal and administrative management and food service systems are in place for the program.

E. Nutrition service providers must provide for the training of all staff engaged in the administration of the program, whether the staff person is paid or not. Training must be related to the specific job responsibilities of each staff member.

4.1.5 (cont.)

F. Nutrition service providers must maintain insurance coverage with a company authorized to do business in Kansas and maintain at least $200,000 per occurrence and $600,000 annual aggregate liability insurance to indemnify and recompense participants and their families for physical, emotional, monetary, and property damages caused by the provider's, their trustee's, employees' or agents' negligent or reckless acts or omissions. Upon written request, the provider shall provide the AAA with written verification of the existence of the required insurance coverage, including copies of the policy's declaration sheets. The AAA shall include in any agreement with a provider the requirement that the provider obtain and maintain insurance coverage, as specified herein.

G. Nutrition service providers must establish general accounting procedures and follow Generally Accepted Accounting Principles. Accounting records must be supported by source documents.

H. Nutrition service providers must maintain control and accountability for all contract funds, real and personal property, and other assets. Nutrition service providers must adequately safeguard all such property and assure that only authorized persons use the property for approved program specific purposes.

I. Nutrition service providers must comply with the auditing requirements in KAR 26-2-9, as amended. The provider must participate in timely and appropriate resolution of audit findings and recommendations.

J. Nutrition service providers must solicit the expertise of a licensed or registered dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services (OAA 339.1) to:

1. Oversee the following functions:

    a. Serve as a resource in nutrition program planning and implementation;

    b. Plan, coordinate, and/or provide nutrition education at congregate settings and for home delivered eligible participants; and

    c. Monitor and provide technical assistance and training as needed in the areas of food purchasing, preparation, and service.

2. Perform the following functions:

    a. Certify that all menus used by the nutrition provider meet policy set by KDADS, and assist in planning menus as needed;

4.1.5.J.2 (cont.)

b. Provide nutrition counseling to participants relative to their special dietary needs, as necessary and if funding is available; and

c. Plan and assure proper preparation and service of modified and therapeutic diets when provided.

K. The dietitian whose services are utilized by the provider to fulfill the requirements listed in paragraphs J and K above must fully disclose any relationship with the food service contractor utilized by the provider to prevent conflict of interest.

L. Nutrition service providers must develop written procedures that assure the availability of meals during an emergency.

M. Certified menus of meals served must be retained for a minimum of three (3) years after the date on which the grant period ends.

4.1.6 Food Management

A. There must be a Person in Charge at every licensed food establishment pursuant to KDA regulations.

B. Food-Borne Illness Prevention and Identification

1. Nutrition service providers must immediately report, in writing, all suspected occurrences of food-borne illness to the appropriate AAA and KDADS.

2. Nutrition service providers must have written procedures for handling suspected cases of food-borne illness.

3. The Person in Charge must be present during food preparation and service of meals that are not pre-packaged.

4. The Person in Charge must know when to restrict or exclude food handlers and when to report illnesses to the food regulatory authority. Food handlers must be free of any communicable disease and comply with the current Food Code published by KDA, including food preparation and service policies and procedures, and health, cleanliness, and hygienic practices.

C. Purchase or Procurement

1. Nutrition service providers must use table settings that are appropriate for older individuals. The nutrition service providers must make appropriate food containers and utensils for individuals with disabilities available, upon request.

4.1.6.C (cont.)

2. All foods contributed to the nutrition service provider must meet the standards of quality, sanitation, and safety that apply to foods that are purchased commercially by the provider. Foods processed, prepared, or canned in the home may not be used in Title III C meals.

3. Nutrition service providers must maintain food inventory records and cost records.

D. Preparation and Service

1. Current menus must be posted at each congregate site, and upon request, must be provided to home delivered meal participant.

2. Standardized recipes must be used in food preparation to assure consistent quality and quantity.

3. The meal service period must be adequate for all participants. Flexible service time may be offered as long as food safety procedures are established.

4. Temperature or "time only" must be used as food safety control during holding, delivery, and service of potentially hazardous food and must comply with the current Food Code.

E. Nutrition service providers that have central kitchens with satellite meal sites, non-traditional settings, home delivered, or catered meals must deliver the meals in a safe and sanitary manner. Food transporting equipment must be cleaned and sanitized daily.

F. Cost Control

1. Nutrition service providers must establish procedures that forecast or estimate attendance. Every effort must be used to keep waste at a minimum.

2. Excess food must not be ordered or prepared for the purpose of having leftovers. Food preparation kitchens with proper storage facilities may freeze food that has not been heated more than once, for future use or use in individual frozen meals.

3. If second helpings are available, they may be offered to participants for immediate consumption.

4. Nutrition service providers, at their discretion and per written food safety policy, may allow participants to take out food and milk remaining from their own served meal.

5. When food has been removed from the premises, its safety is the sole responsibility of the participant.

4.1.6.F (cont.)

6. Extra or unserved food not served must not be given or sold to an employee or volunteer.

4.1.7 Menu Certification Criteria

A. The menu must consider the special needs of older adults.

B. The meals must comply with federal nutrition policy in the most recent Dietary Guidelines for Americans published by the Secretary of Health and Human Services and the Secretary of Agriculture.

   1. A minimum of 33 1/3% of the DRIs when one (1) meal a day is provided and

   2. A minimum of 66 2/3% of the DRIs when two (2) meals a day are provided.

C. The menus must be appealing and demonstrate good menu planning techniques. Offering choices of foods on a daily basis is strongly encouraged.

D. The menu must incorporate input solicited from older adults, including their food preferences and needs.

E. Menus must be made available for review two (2) weeks prior to meal preparation.

F. A Registered or Licensed Dietitian must certify, in writing, that the menu conforms to menu certification criteria in Sections 4.1.8 and 4.1.9.

   1. The recommended approach to meal planning is food based.

   2. A food based planning approach that exemplifies the most recent Dietary Guidelines for Americans using the recommended servings for the food groups as well as fats and oils, and sweets and added sugars may be used (see Section 4.1.8 for details).

   3. A nutrient-based planning approach using computer analysis leading to meals that are consistent with the most recent Dietary Guidelines for Americans may be used (see Section 4.1.9 for details).

G. A maximum of two (2) meals per day, per participant, is allowed;

4.1.7 (cont.)

H. Nutrient intake recommendations for meals provided to each participant are shown on Table 1, Dietary Reference Intakes (DRIs) for Older Adults. Meals planned using the food based approach are considered to meet nutrient intake recommendations when the serving sizes and guidelines regarding food components are followed. When using a food-based planning approach, computerized nutrient analysis may be helpful, but is not essential, as long as nutrition projects use an accepted method to control the calorie, saturated fat, added sugars, and sodium content of the meals. Meals planned using a nutrient-based planning approach are considered to meet nutrient intake recommendations when menus are appropriate in calorie content and meet the recommended dietary allowance (RDA) or adequate intake (AI) values. All nutrients are important.

I. Menus will show a reduction in sodium over time as low sodium products are commercially available. The sodium amount in Table 3 is the starting point. Providers should strive to be below this recommendation. The goal is 33 1/3 percent of the Dietary Guidelines for Americans 2010 recommendation, or 500 mg per meal.

J. OAA funding does not cover the cost of dietary supplements, including vitamin or mineral supplements. Fortified foods must be used to meet nutrient intake recommendations for Vitamins B12 and D.

K. Table 1. Dietary Reference Intakes (DRIs): Recommended Dietary Allowances and Adequate Intakes, Vitamins, Minerals and Macronutrients – Food and Nutrition Board, Institute of Medicine, National Academies

	Vitamin A (μ/d)[a]	Vitamin C (mg/d)	Vitamin D (μ/d)[b,c]	Vitamin E (mg/d)[d]	Vitamin K (μ/d)	Thiamin (mg/d)	Riboflavin (mg/d)	Niacin (mg/d)[e]	Vitamin B_6 (mg/d)
Males 51-70 y	**900**	**90**	**15**	**15**	120*	**1.2**	**1.3**	**16**	**1.7**
>70 y	**900**	**90**	**20**	**15**	120*	**1.2**	**1.3**	**16**	**1.7**

	Folate (μ/d)[f]	Vitamin B_{12} (μ/d)[g]	Calcium (mg/d)	Iron (mg/d)	Magnesium (mg/d)	Sodium (g/d)	Carbohydrate (g/d)	Fiber (g/d)	Protein[h] (g/d)
Males 51-70 y	**400**	**2.4**	**1000**	**8**	**420**	**1.3***	**130**	30	**56**
>70 y	**400**	**2.4**	**1200**	**8**	**420**	**1.2***	**130**	30	**56**

Note: This table (taken from the DRI reports, see www.nap.edu) presents Recommended Dietary Allowances (RDAs) in bold type and Adequate Intakes (AIs) in ordinary type followed by an asterisk (*).
An RDA is the average daily dietary intake level; sufficient to meet the nutrient requirements of nearly all (97-98 percent) healthy individuals in a group. It is calculated from an Estimated Average Requirement.
If sufficient scientific evidence is not available to establish an EAR, and thus calculate an RDA, an AI is usually developed.

4.1.7.K (cont.)

The AI is believed to cover the needs of all healthy individuals in the groups, but lack of data or uncertainty in the data prevent being able to specify with confidence the percentage of individuals covered by this intake.
[a] As retinol activity equivalents (RAEs). 1 RAE = 1 µg retinol, 12 µg β-carotene, 24 µg α-carotene, or 24 µg β-cryptoxanthin. The RAE for dietary provitamin A carotenoids is two-fold greater than retinol equivalents (RE), whereas the RAE for preformed vitamin A is the same as RE.
[b] As cholecalciferol. 1 µg cholecalciferol = 40 IU vitamin D.
[c] Under the assumption of minimal sunlight.
[d] As α-tocopherol. α -tocopherol includes RRR-α-tocopherol, the only form of α-tocopherol that occurs naturally in foods, and the 2R-stereoisomeric forms of α-tocopherol (RRR-, RSR-, RRS, and RSS-α-tocopherol) that occur in fortified foods and supplements. It does not include the 25-stereoisomeric forms of α-tocopherol (SRR-, SSR-, SRS-, and SSS- α-tocopherol), also found in fortified foods and supplements.
[e] As niacin equivalents (NE). 1 mg of niacin = 60 mg of tryptophan.
[f] As dietary folate equivalents (DFE). 1 DFE = 1 µg food folate = 0.6 µg of folic acid from fortified food or as a supplement consumed with food = 0.5 µg of a supplement taken on an empty stomach.
[g] Because 10 to 30 percent of older people may malabsorb food-bound B12, it is advisable for those older than 50 years to meet their RDA mainly by consuming foods fortified with B12 or a supplement containing B12.
[h] Based on g protein per kg of body weight for the reference body weight, e.g., for adults 0.8 g/kg body weight for the reference body weight

4.1.8 Food Based Meal Pattern

A. The food based meal pattern, Table 2, provides approximately 1/3 of the food group recommendations of the 2010 Dietary Guidelines at the level of 2000 calories /day.

B. The 2010 Dietary Guidelines meal pattern provides at least 33 1/3% of the nutrients needed by older (ages 51-70 years) adults with the exception of potassium and vitamins D and E. The meal pattern, when using representative foods that are in nutrient-dense forms, is adequate in the following nutrients: protein, total lipid (approx. 32% of calories, with approx. 8% of calories as saturated fats), carbohydrate (approx. 51% of calories), total dietary fiber, vitamins A, B-6, B-12, C and K; thiamin, riboflavin, niacin, folate, calcium, iron, magnesium, phosphorus, zinc, copper and selenium. (Source: www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/DGAC/Report/AppendixE-3-1-adequacy.pdf)

C. Almost all foods selected for the weekly meal pattern should be lean or low-fat, and should be prepared with minimal, if any, added fats, oils, sugars or salt.

D. Food Components

1. **Protein**: Various types of protein foods should be served each week.

   a. For programs serving 5 meals/week, it is recommended to serve chicken or turkey twice a week; and seafood, pork and beef each once a week.

   b. For programs serving 7 meals/week, it is recommended to serve chicken or turkey ten times every four weeks; and seafood, pork and beef each six times every four weeks.

4.1.8.D.1 (cont.)

c. For programs serving 1 meal/week, it is recommended to vary types of protein served.

d. One-half to one egg, and nuts, seeds and soy foods may also be served weekly, if desired, in addition to the protein foods.

e. Lean meat/poultry offerings include ground beef and pork with 10 percent fat, processed poultry products with less skin and fat, 97 percent fat free ham, 95 percent fat free turkey ham.

f. Processed, smoked, or cured meat or a high-sodium-content protein should be limited to no more than one serving per week (for example, cold cuts, ham, hot dogs, sausage, canned fish). Also limit canned soups, sauces, gravies and bouillon with sodium.

2. **Grains**:

a. At least half of grains served each week should be whole grains. It is acceptable to serve one ounce-equivalent each of whole grain and enriched grains at a meal. One ounce-equivalent is: 1 ounce or 1 slice of bread; ½ cup cooked pasta or rice, 1 ounce or ½ to 1 ¼ cups, depending on cereal type, of dry cereal. Refer to the Nutrition Facts of specific products.

b. Whole grain examples include: whole-wheat breads/rolls/bagels/English muffins, whole grain pastas, whole-grain cereals, oats, whole grain cracker, brown rice.

c. Enriched grain examples include: white breads/rolls/bagels/English muffins, enriched pastas, stuffing made from white breads, 6-inch enriched corn or wheat tortillas, enriched grain cereals, enriched crackers, white rice.

d. Limit use of quick breads such as cornbread, biscuits, and muffins as well as salted crackers to reduce sodium content.

e. Use trans-fat free products.

3. **Fruit**:

a. Includes all fresh; canned fruit packed in water, light syrup and 100% juice packed; frozen without added sugars; dried without added sugars; and 100% fruit juice. Very little fruit should be served as juice. Examples of fruits include: apples, apricots, bananas, berries, cherries, grapes, kiwi, mangoes, melons, mixed fruit, nectarines, oranges, peaches, pears, pineapple, plums, raisins, and tangerines.

4.1.8.D (cont.)

4. **Vegetables**:

   a. Includes all cooked and raw fresh, frozen, canned and 100% vegetable juice. Various types of vegetables should be served each week. Most should be prepared with no added salt or fats.

   b. To limit sodium content, serve canned vegetables with no more than 480 mg sodium/serving, low sodium, reduced sodium, no added salt, and frozen salt free. Also limit pickled or brined vegetables and canned soups, sauces, gravies and bouillon with sodium.

   c. For 5 meals/week, it is recommended to serve:

      1. Red/Orange: Twice a week, ½ cup raw/cooked/juice red or orange vegetables (examples: carrots, pumpkin, red and orange peppers, sweet potatoes, tomatoes, winter squash)

      2. Starchy: Twice a week, ½ cup cooked starchy vegetables (examples: corn, green peas, hominy, lima beans, water chestnuts, white potatoes)

      3. Legumes: Once a week, ½ cup cooked dry beans and peas (examples: black, black-eyed peas, chickpeas/garbanzos, kidney, lentils, navy, pintos, split peas, soy)

      4. Dark Green: Twice a week, 1 cup raw leafy or ½ cup raw cooked dark green vegetables (examples: bok choy, broccoli, butterhead or bibb lettuce, chard, collard greens, kale, romaine lettuce, spinach, turnip greens)

      5. Other Vegetables: Three times a week, 1 cup raw leafy or ½ cup raw/cooked "other" vegetables (examples: asparagus, avocado, beets, Brussels sprouts, cabbage, cauliflower, celery, cucumbers, eggplant, green beans, green peppers, iceberg lettuce, mushrooms, okra, olives, onions, parsnips, radishes, snow peas, summer squash, turnips, wax beans)

5. **Dairy**:

   a. Most dairy servings should be fat-free or low-fat (1%) and without added sugars. One serving is 1 cup milk, fortified soy beverage, or yogurt; or 1 ½ ounces natural cheese (such as cheddar); or 2 ounces processed cheese (such as American). Dairy food examples include: all milk, including lactose-free/reduced; cheeses; fortified soy beverages; yogurts and frozen yogurts; and dairy desserts. Not included are: cream, sour cream or cream cheese.

4.1.8.D.5 (cont.)

b. Low-fat, reduced fat and light cheeses and cheeses made from skim or fat free milk are recommended when serving cheese.

c. Cheese should be limited to no more than 3 ounces per week because of high sodium content.

E. Table 2. Food Based Meal Pattern

Food Group (See text that accompanies this meal pattern for guidelines in making serving selections.)	**Weekly Average Serving Size per Meal** (See text that accompanies this meal pattern for guidelines in serving sizes.)	**Frequency**
Protein	2 ½ ounces of cooked edible portion	Every meal
Whole and Enriched Grains	2 ounce equivalents	Every meal. At least half of grains must be whole grains.
Fruit	2/3 cup (or 1/3 cup if dried)	Every meal
Vegetables	1 cup equivalent	Every meal
Dairy	1 cup fat free or low fat (1%) fluid milk or yogurt; or 1 ½ ounces natural cheese; or 2 ounces processed cheese	Every meal
Fats and Oils	1 teaspoon soft margarine/vegetable oil; or 1 tablespoon regular salad dressing; or 2 tablespoons low fat salad dressing. This category is met when higher fat, dairy, protein and baked goods are part of the meal.	Every meal
Sweets and Added Sugars	1 ½ tablespoons jam/jelly; or ½ cup regular gelatin/pudding/ice cream; or fruits with added sugar; or baked desserts	Weekly

4.1.9 Computer Nutrient Analysis Requirements

A. When using a nutrient-based planning approach, the nutrient analysis software must be reliable and contain a current nutrient database. The most reliable nutrient analysis software uses a large nutrient database, like the USDA Nutrient Database for Standard Reference (SR), which is updated annually.

4.1.9 (cont.)

B. The nutrition service provider must utilize standardized recipes at each of its production facilities that prepare certified menus. Standardized recipes are required to ensure an accurate and valid nutrient analysis. Therefore, nutrient analysis software must be customized to integrate the most current, accurate nutrient data from vendors, standardized recipes, the U.S. Department of Agriculture (USDA), and other relevant resources.

C. The nutrition service provider or the entity that conducts the nutrient analysis must have the technical capacity to complete the entire nutrient analysis.

D. Table 3 represents the nutrient targets required to be met on a daily basis and/or as a weekly average.

Nutrient	DRI Target Values Per Meal	Compliance Range One Meal
Daily Averaged		
Calories (Kcal)	650-750 calories (Kcal)	600-1000 calories (Kcal)
Protein	25 grams or higher	20 grams or higher
Averaged Over The Number of Days of Meal Service Per Week		
Fat (% of Total Calories)	20-30% of total calories	20-35% of total calories
Saturated fat	10% of total calories or less	10% of total calories or less
Trans fat	0 grams per serving, per Nutrition Facts food labels	0 grams per serving, per Nutrition Facts food labels
Vitamin A	300 micrograms (µg) RAE (990 IU) or higher	250 µg RAE (825 IU) or higher
Vitamin C	30 milligrams (mg) or higher	25 mg or higher
Nutrient	**DRI Target Values Per Meal**	**Compliance Range One Meal**
Averaged Over The Number of Days of Meal Service Per Week (Continued)		
Calcium	400 milligrams (mg) or higher	300 mg or higher
Sodium***	800-1,000 milligrams (mg) or less	1,200 mg or less
Fiber	9 grams (gm) or higher	7 gm or higher

***See 4.1.7.I for recommendation

4.1.10 Special Menus

A. Criteria

1. To the maximum extent practical, nutrition service providers may provide special menus to meet the particular dietary needs arising from the health requirements, religious requirements, or ethnic backgrounds of eligible participants. To determine feasibility, the provider must use the following criteria:

    a. There are sufficient numbers of individuals who need the special menus to make the provision practical;

    b. The food and skills necessary to prepare the special menus are available in the planning and service area;

    c. Proper preparation and service of special menus is assured by thorough training of personnel.

2. The provision of special menus must be appropriate.

    a. Special menus are an appropriate intervention to meet needs arising from health requirements (including being at High Nutritional Risk based on a Nutrition Risk Score) when based on a recommendation by an appropriate health professional, such as a physician or registered/licensed dietitian, as part of an overall medical nutrition therapy plan.

    b. The first (and least costly) approach in the provision of special menus as an intervention/treatment to meet needs arising from health requirements is modifying or enhancing the nutrient content and density and/or texture of conventional foods. Every effort should be made to continue to provide nutrients via culturally acceptable food, texture modified if necessary, before making the decision to use medical foods and food for special dietary uses as replacements for all or part of meals.

B. Carbohydrate Controlled

1. Use sugar substitutes and sugar free food items.

2. Limit breading, gravies and sauces.

3. May substitute dark green, red/orange, or “other” vegetables for one ounce of grains.

4. May substitute dark green, red/orange, or “other” vegetables for the starchy vegetables and cooked dried beans and peas.

4.1.10.B (cont.)

5. Use fresh fruits; frozen without added sugar; dried without added sugar; light syrup, juice packed or water packed fruits.

6. May substitute 1 ½ ounces low fat natural cheese or 2 ounces low fat processed cheese for one cup milk.

C. Mechanically Altered Diet

1. A mechanically altered diet may be provided to facilitate oral intake by altering the texture or consistency of food, i.e., chopping, pureeing, thickening, or blending.

2. Mechanically altered diets must comply with the menu certification criteria (Section 4.1.7)

3. The eligible participant is responsible for determining whether the mechanically altered diet would meet his/her own health needs.

D. Therapeutic Diets

1. Nutrition service providers are not required to offer therapeutic diets. A therapeutic diet may be developed to meet the specific health needs of an eligible participant, at the discretion of the meal provider.

2. A written diet order or nutrition prescription from the participant's physician must be on record in the participant’s file at the nutrition provider’s office prior to an eligible participant’s receipt of a therapeutic diet.

3. A Licensed or Registered Dietitian must provide nutrition counseling for eligible participants served a therapeutic diet.

4. A diet manual recognized by the Kansas Dietetic Association or the Academy of Nutrition and Dietetics must be used to plan the modifications or enhancements.

5. The Licensed or Registered Dietitian, through training of personnel, must assure proper preparation and service of therapeutic diets.

6. The written diet order or nutrition prescription must be reviewed at least annually by the Dietitian working with the provider and by the eligible participant’s physician.

E. Medical Foods and Foods for Special Dietary Uses

1. Nutrition service providers are not required to offer medical foods and foods for special dietary uses.

4.1.10.E (cont.)

2. The OAA, including NSIP, will pay for medical foods and foods for special dietary uses when all of the following conditions are met:

   a. It is indicated for some older individuals who are malnourished, at risk of malnutrition, or with disease-related special nutritional needs. These include older individuals who, because of anatomical, physiological, or mental problems, cannot meet their nutritional needs by eating a nutritionally balanced diet of solid or texture-modified foods, or for those who have increased or altered metabolic needs due to illness, surgery, or other special conditions.

   b. There is a recommendation by an appropriate health professional, such as a physician or registered/licensed dietitian, as part of an overall medical nutrition therapy plan for the individual, and the plan is re-evaluated and updated at least semi-annually. The decision to use medical foods or foods for special dietary uses should only come after a comprehensive, interdisciplinary evaluation has been completed that includes client/caregiver input and an in-depth nutrition assessment justifying it as the appropriate choice.

   c. The individual must be provided with a minimum of 33 1/3% of the DRI except in cases where the individual's specific medical nutrition therapy plan dictates otherwise; and

   d. If the medical food or food for special dietary uses is used as

      i. a substitution for part of the conventional meal components, the combination of the medical food or foods for special dietary uses and conventional foods must meet the criteria in Section 4.1.7; or

      ii. replacement of a conventional meal, the medical food or food for special dietary uses must meet the criteria in Section 4.1.7 and be used as a replacement because a conventional meal, even with modifications, is contraindicated.

3. When a medical food or food for special use is provided in addition to a conventional meal, KDADS views the meal and medical food or food for special dietary uses together as constituting a single meal and will not reimburse separately.

4.1.11 Program Income

A. Nutrition service providers must develop written procedures that safeguard and account for all program income.

4.1.11 (cont.)

B. The cost of the meal must be updated at a minimum at the beginning of each fiscal year (October 1). The cost of the meal may be rounded up to the next 25 cents for ease of collection.

C. The provider agency must recover the cost of the meal from individuals not meeting the eligibility criteria for funding sources in Sections 4.2.1 and/or 4.3.1.

D. Contributions

1. The provider must inform each participant of the opportunity to voluntarily contribute to the cost of the service.

   a. The privacy of the participant with respect to the contribution must be protected.

   b. A suggested contribution must take into consideration the income ranges of eligible participants in local communities and other provider sources of income.

   c. An eligible participant will not be denied service if unable to contribute to the cost of the meal. Voluntary contributions will be considered program income and will be used only to expand nutrition services.

2. Each provider must establish a suggested flat or sliding contribution schedule for eligible participants.

   a. The suggested contribution schedule for eligible participants and the cost of the meal must be posted in the congregate meal site. The posted notice must indicate that non-eligible participants must pay the cost of the meal.

   b. For home delivered meal participants, a notice containing the same information posted at the congregate meal site must be provided to each home delivered participant at the time the meal service is initiated and at least annually thereafter.

E. Vision Card Program: Nutrition service providers must establish procedures to assist participants in utilizing benefits available to them under the Vision Card Program by:

1. Providing current information about the Kansas Vision Card program to participants in all nutrition programs;

2. Coordinating activities with agencies responsible for administering the Vision Card program; and

3. Becoming certified to accept the Vision Card for meal contributions.

4.1.11 (cont.)

F. Disposition of Program Income (45 CFR 92.25)

1. The AAAs may only use the addition alternative to spend program income earned under Title III of the OAA.

2. Program income must be used for "current cost"; that is, the income must be expended for costs incurred during the same budget period in which the income is earned.

3. The following are alternatives grantees and subgrantees may use to comply with above polices if it can be shown that meals will be increased:

   a. Maintenance of existing meal levels above levels that can be maintained on OAA funds;

   b. Establishment of central kitchens;

   c. Alterations and/or renovations to comply with Section 504 of the Rehabilitation Act, as amended, and the Americans with Disabilities Act of 1990;

   d. Match for other federal funds; and

   e. Other uses documenting an increase in meals.

G. KDADS and the AAA must approve all plans for use of program income by an OAA Title III C grantee and/or subgrantee.

4.1.12 Catering

A. Nutrition service providers may enter into contracts to provide meals for other functions if those proposed contracts will not compromise their obligation to provide meals under the OAA Title III C program.

B. At a minimum, the price per meal charged by the program must include all the appropriate costs incurred in the provision of the meal, including:

1. Primary meal costs – purchased food, labor, supplies, NSIP commodities and cash, and other costs (e.g., bulk food transportation if this service is provided);

2. Associate meal costs – building space and utilities, maintenance and repair of equipment, depreciation of capital equipment, and renovation;

3. Site operation costs – site manager salary if the site manager supervised food preparation staff; and

4.1.12.B (cont.)

4. Project management – appropriate management costs.

C. All costs must be allocated to the appropriate program or contract utilizing generally acceptable accounting principles.

D. For financial reporting purposes, resources earned from the sale of these meals must be reported as a reduction in the total cost of the project. The OAA Title III C budget must include the cost of production for all meals, less the cost of meals to be sold, but not the revenue derived from the sale of those meals. When the meals are billed, a receivable must be set up for the amount of the billing and the total expenses reduced by this amount. Contractual agreements must ensure that payment is received within thirty (30) days of billing. Records of the number of meals sold, costs for the production of those meals, and revenues to purchase those meals under each contract must be maintained by the project.

4.1.13 Vouchers

A. Nutrition service providers, both congregate and home delivered, may enter into contracts to purchase meals using vouchers as the method of payment.

4.2 Congregate Nutrition Services

4.2.1 Eligibility Criteria

A. Individual 60 years of age or older and the spouse of that individual regardless of his or her age; or

B. Volunteer less than 60 years of age who provides volunteer services during meal hours, as long as his or her meal will not deprive an eligible participant of a meal; or

C. Individual less than 60 years of age with disability who resides in a housing facility occupied primarily by individuals 60 years of age or older where congregate nutrition services are provided; or

D. Individual less than 60 years of age with disability who resides in a home with and accompanies an individual 60 years of age or older.

4.2.2 Congregate Nutrition Service Provider Requirement

A. Congregate nutrition service providers must do the following:

1. Provide meals five (5) or more days a week (except in rural areas where such frequency is not feasible and a lesser frequency is approved by KDADS);

2. Provide at least one hot or appropriate meal per day and any additional meals that the provider may elect to provide;

3. Provide the meals in a congregate setting; (Nutrition service providers, at their own discretion and per written policy, may allow participants to take out their own served meal); and

4. Provide nutrition education, nutrition counseling, nutrition assessment, and nutrition screening services, as appropriate, based on the needs of eligible participants.

B. The service area and meals served by a congregate nutrition service provider must be of sufficient size and number for the economical and efficient delivery of nutrition services.

C. Congregate nutrition service providers must establish an advisory group, which will include eligible participants of the program and individuals who are knowledgeable of the needs of older adults. The group must meet at least quarterly to advise Area Agency on Aging (AAA) and/or provider staff on topics such as the meal program, including administration, budget, activities, and menus.

D. Congregate settings must be located in areas where the greatest need is evident and where other services are accessible to the participants. If in a residential area, it should be within walking distance of the majority of eligible participants.

4.2.2 (cont.)

E. Congregate nutrition centers and satellite meal sites must comply with local and state health, fire, safety, building, zoning, and sanitation laws, ordinances, codes and the Americans with Disabilities Act (ADA) requirements. The service provider must maintain appropriate documentation.

F. Congregate settings must be neat and clean, and have appropriate lighting, ventilation, and furnishings for eligible participants.

4.2.3 Establishing, Relocating, or Closing of Congregate Settings

A. Establishment of congregate settings must be approved by KDADS through approval of the Area Plan or revisions thereto.

B. New and relocated congregate settings should be located in areas of greatest social and economic need.

C. The AAA must document, for each new center, the development for comprehensive and coordinated service delivery system, i.e., focal point or multipurpose center. In those cases in which a congregate setting is located within a multipurpose senior center, a written agreement detailing the responsibilities of all providers concerned must be made prior to establishment of the congregate setting.

D. The AAA must develop and maintain written procedures and policies concerning the closing and relocation of congregate settings.

E. Once the decision has been made to close or relocate a setting, KDADS shall be notified, in writing, and the notification shall include the following:

1. The rationale for the closure or relocation;
2. A statement describing the impact of the setting closure upon surrounding congregate settings; and
3. A description of the convenience the eligible participants will have to another congregate setting and/or nutrition services

4.3 Home Delivered Nutrition Services

4.3.1 Eligibility Criteria

A. Eligibility requirements for home delivered nutrition services:

1. Individual 60 years of age or older who is homebound (see definition of ”homebound” in Section 4.1.3); or

2. Individual 60 years of age or older who is isolated (see definition of ”isolated” in Section 4.1.3); or

3. Individual 60 years of age or older who is a caretaker, as long as it is in the participant's best interest (see definition of ”caretaker” in Section 4.1.3; OAA Title III B only);

4. Spouse of an eligible participant as long as it is in the participant's best interest; or

5. Individual with disability or dependent individual who resides in a non-institutional setting with an eligible participant, and it is in the participant's best interest; or

6. Registered congregate meal participant who needs home delivered meals due to an illness or health condition (i.e., congregate meal- illness related home delivered or CMELH). The participant may only receive CMELH meals for up to 30 consecutive days per calendar year.

B. An eligible participant may only receive a home delivered meal if his or her special dietary needs can be appropriately met by the program through a meal which conforms with the established standards, i.e., the meal available would not jeopardize the health of the individual.

4.3.2 Home Delivered Nutrition Services Provider Requirements

A. Area Agencies on Aging must ensure that each home delivered nutrition service provider makes provisions for nutrition education, nutrition counseling, nutrition assessment, and nutrition screening services, as appropriate, based on the needs of eligible participants.

B. Home delivered nutrition service providers must do the following:

1. Provide meals five (5) or more days a week (except in rural areas where such frequency is not feasible and a lesser frequency is approved by KDADS); and

2. Provide at least one hot, cold, frozen, dried, canned, fresh or supplemental foods (with a satisfactory storage life) meal per day and any additional meals which the nutrition service provider may elect to provide.

4.3.2 (cont.)

C. Home delivered nutrition service providers must coordinate with other in-home service providers to implement a coordinated system of comprehensive in-home care.

D. Home delivered nutrition service providers must establish a procedure for securing input on the quality of the services from eligible participants.

E. Home delivered nutrition service providers must develop and implement procedures for routinely encouraging those eligible participants whose conditions improve to participate in the Congregate Nutrition program.

TABLE OF CONTENTS

SECTION 5

Reserved

TABLE OF CONTENTS

SECTION 6: ELDER RIGHTS

6.1 Reserved

6.2 Reserved

6.3 Legal Assistance

6.3.1 Legal Assistance Development
6.3.2 Priority Areas of Law
6.3.3 Area Agency on Aging Responsibilities
6.3.4 Legal Service Provider Requirements

6.3 Legal Assistance

6.3.1 Legal Assistance Development

A. Program Description and Purpose

The Older Americans Act of 1965(OAA), as amended, designates legal assistance as a priority service funded under Title III-B [42 U.S.C. 3026(a)(2)]. The 1992 amendment created a Title VII concerning Allotments for Vulnerable Elder Rights programs for the prevention of elder abuse, neglect, and exploitation; state elder rights and legal assistance development programs; and outreach, counseling, and assistance programs. As such, the funding of legal assistance by each Area Agency on Aging (AAA) is mandatory. Legal assistance services are accessible and available throughout each of the 11 planning and service areas (PSAs) in Kansas.

B. Definitions

Community Education: Presentations given to older individuals or their caregivers by legal service staff on a specific legal topic.

Older Individual: An individual who is 60 years of age or older.

Outreach: Interventions initiated by an agency or organization to identify or target potential customers or their caregivers to encourage their use of legal assistance services and benefits.

C. Program Purpose

1. Legal assistance services provide access to the system of justice by offering advice and representation by a legal provider who acts as an advocate for the socially and/or economically needy older individual to ensure the following:

   - Access to essential services and/or financial resources;
   - Assistance in understanding their rights and exercising choices; and
   - Protection of the older individual's right to be autonomous and to retain his or her dignity.

2. Programs are to foster a high quality, cost effective service that is integrated into the aging services network and accessible throughout each PSA, and to develop and maximize the use of other resources.

6.3.1 (cont.)

D. Target Population

1. The AAAs and legal assistance service providers shall, in consultation with the Kansas Department for Aging and Disability Services' (KDADS) Legal Service Developer, jointly develop plans to target legal assistance services to older individuals with the greatest social need and/or greatest economic need, as defined in Section 1.1.

2. AAAs and legal assistance providers shall identify those older individuals who are most vulnerable and in need of legal assistance. Priority for legal assistance services shall be given to those older individuals who meet any of the following:

   - Resident of an adult care home;
   - Terminally ill;
   - At risk of admission to, or denied placement in, an adult care home;
   - Difficulty accessing health care;
   - Homeless;
   - Mentally ill or developmentally disabled;
   - Seeking public benefits for which they are eligible;
   - Living in a rural area;
   - Language barrier;
   - In need of or under guardianship;
   - At risk or victim of abuse, neglect or financial exploitation (including fraudulent and deceptive financial and consumer practices); and
   - Physically or socially isolated.

3. Consideration should be given at the local level as to the availability of other resources to meet the legal needs of targeted populations. This target listing is not exhaustive or in a mandatory priority order.

6.3.2 Priority Areas of Law

The legal services provider must be capable of providing legal assistance in the service categories listed below unless the provider can demonstrate to the AAA that the service category is already being provided in their area to older Kansans with the greatest social need and/or greatest economic need. The AAA shall ensure that priority is given to those categories marked with an asterisk.

6.3.2 (cont.)

A. Protective Services

1. Financial Power of Attorney *
2. Advance Directives (Living Wills, Durable Power of Attorney (DPOA) for Health Care) *
3. Guardianship/Conservatorship *
4. Abuse and Neglect *
5. Financial Exploitation *

B. Income

1. Social Security Disability
2. Social Security Retirement
3. Railroad Retirement
4. Unemployment Compensation
5. Private Pension
6. Tax Refunds
7. Workers' Compensation
8. Veterans' Benefits
9. Division of Assets *

C. Public Benefits

1. Supplemental Security Income
2. Supplemental Nutrition Assistance Program (SNAP, f/k/a Food Stamps)
3. Nutrition Programs
4. Temporary Assistance to Families (TAF)
5. Energy Assistance
6. General Assistance

D. Health Care

1. Private Medical Insurance/COBRA
2. Medicare *
3. Medicaid/Medikan *
4. Long Term Care Insurance
5. Collections
6. Long Term Care
7. Home and Community Based Services for Frail Elderly (HCBS/FE)

E. Housing/Real Estate

1. Federal Subsidized Housing *

6.3.2.E (cont.)

2. Home Ownership *
3. Landlord/Tenant *
4. Property Tax
5. Mortgage/Contract
6. Other Property Ownership

F. Consumer/Financial

1. Life Care Contracts
2. Utilities
3. Financial/Tax Counseling *
4. Collections (non-health)
5. Consumer Complaints *
6. Insurance (non-health)
7. Bankruptcy *
8. Funerals

G. Individual Rights

1. Americans with Disabilities Act (ADA)/Disability Rights *
2. Discrimination, including age *
3. Immigration/Naturalization
4. Resident's/Patient's Rights *
5. Crime Victims
6. Grandparent Rights

H. Miscellaneous

1. Divorce/Separation
2. Custody/Adoption
3. Will/Estate Planning
4. Probate of Estate
5. Employment
6. Traffic

6.3.3 Area Agency on Aging Responsibilities

Each Area Agency on Aging (AAA) shall meet the following requirements:

A. Assure access to legal assistance throughout the PSA by contracting with one or more Legal Services providers that meet requirements specified in 45 CFR 1321.71 and requirements in Section 6.3.4.

6.3.3 (cont.)

B. Provide OAA Title III-B funding at a level equal to or above the minimum established by KDADS through the adequate proportions policy.

C. Work with the Legal Services provider(s), to expand access to legal assistance for the targeted population and to address priority needs. (See Sections 6.3.1 and 6.3.2)

D. Work with the AAA's Legal Services provider(s) to provide community education on priority areas of law (see Section 6.3.2) to reach and serve targeted groups.

E. Develop and implement grievance procedures for clients, applicants, and past clients who file complaints or grievances with the AAA about the legal assistance program. (See Section 1.3)

F. Review and approve each Legal Services provider's policy and protocol for referral of fee generating cases and conflicts of interest as required in Section 6.3.4.

G. Monitor and conduct an annual assessment of each Legal Services provider under contract with the AAA.

H. Provide the Legal Services provider(s) with a current copy of AAA and KDADS policies and procedures that apply to providers in general and to legal assistance specifically, and supply relevant changes in these policies and procedures in a timely manner.

I. Protect client confidentiality in accordance with the Kansas Rules of Professional Conduct, federal rules and regulations, and Kansas statutes and administrative regulations.

J. Respect the professional relationship of any client with any attorney or non-attorney advocate employed by, or volunteering for, the Legal Services provider by not interfering with, or intervening on behalf of, the client or the provider.

K. Include Legal Services provider requirements identified in Section 6.3.4 and any amendments thereto, in provider contracts.

L. Work with Legal Services providers to develop a method for surveying client satisfaction and needs, and to assure that the views of older individuals are solicited and considered as to the operation of the legal assistance program.

M. Develop legal assistance service goals as a part of the Area Plan.

N. Promote private bar involvement, including the establishment or expansion of legal assistance services provided pro bono or on a reduced fee basis, particularly for wills and advance directives.

6.3.3 (cont.)

O. Submit the following information for OAATitle III-B service providers to KDADS's Legal Service Developer:

1. a current listing of attorneys responsible for services to older individuals;
2. the name of the supervising attorney, if any; and
3. the primary supervising attorney for paralegal/non-lawyer advocates.

P. Submit KDADS Form SS-028, Legal Service Reporting Form, to KDADS by the 20th of the month following the end of each semi-annual reporting period.

6.3.4 Legal Service Provider Requirements

A. Provider Staffing Requirements

1. All attorneys providing legal assistance services funded by OAATitle III-B must be authorized to practice law in the State of Kansas.

2. All attorneys must demonstrate experience or capacity to provide quality legal services in the majority of priority areas of law as identified in Section 6.3.2.

3. All providers must have at least two years legal experience unless directly supervised by an attorney who has a minimum of two years of law practice.

4. Paralegals must have direct and regular supervision by a qualified attorney and be provided skills training and training in the priority areas of law.

5. All attorneys must attend a minimum of three (3) hours of Continuing Legal Education on elder law topics annually.

6. All Legal Services providers must offer sufficient training to all staff members providing legal assistance services funded by OAATitle III-B and maintain documentation of each employee's training sessions for a period of five (5) years after the last day on which legal assistance services were provided by the employee.

7. All Legal Services providers must maintain insurance coverage for malpractice.

B. Legal Services Provider Requirements

Each Legal Services Provider shall meet the following requirements:

1. Provide effective, high quality administrative and judicial representation for eligible individuals in the mandated priority categories set forth in Section 6.3.2,

6.3.4.B (cont.)

except where the Legal Services provider can demonstrate to the AAA that another provider is delivering the service in accordance with Section 6.3.2.

2. Use OAATitle III-B funds and other funds contracted for from the AAA to increase the level of legal assistance available to eligible individuals. OAATitle III-B funds shall not supplant funds from other federal or non-federal sources.

3. Provide legal assistance to any individual 60 years of age or older, regardless of their level of income or resources, if the client is receiving legal assistance funded by
4. Title III-B. The provider may only question the client about financial circumstances as a part of the process of providing legal advice, counsel, and representation, and for the purpose of identifying additional resources to which the client may be entitled.

5. Give clients a free and voluntary opportunity to contribute to the cost of the services they receive and ensure privacy with respect to all solicitations, contributions, or donations. The method of announcing the opportunity to contribute shall not discourage the utilization of the service by the contributor or any other potentially eligible individual in the community.

6. Use all voluntary contributions received from OAATitle III-B clients to expand legal assistance services to elderly individuals.

7. Subcontract or delegate an interest or obligation arising under a Title III-B contract ***only with*** prior written consent from the AAA.

8. Have knowledge of, and access to, the OAA and the CFRs governing legal assistance, including 45 CFR 1321.71 and 45 CFR 1600 et seq.

9. Maintain client confidentiality, including reports, in accordance with the Kansas Rules of Professional Conduct, the attorney-client privilege, and the Older Americans Act.

10. Deliver services to the targeted client population, including clients who are institutionalized, homebound, isolated, or those in community based care programs, as needed. (See Section 6.3.1.D)

11. Provide support to other organizations' advocacy efforts made on behalf of elderly Kansans as allowed by law.

6.3.4.B (cont.)

12. Provide outreach services as an integral part of the contracted legal assistance outreach efforts, which shall identify clients eligible for assistance and apprise them of the availability of this service. The provider shall ensure that legal assistance services are made known to the minority community, including outreach and information disseminated to non- and limited English speaking older individuals and to constituent agencies acting on their behalf.

13. Work with the AAAs to provide community education on priority areas of law (see Section 6.3.2) to reach and serve targeted groups.

14. Develop a coordination of services agreement with the local Legal Services Corporation grantee if the provider is not a Legal Services Corporation funded program. The agreement shall detail the type of cooperation and coordination each program shall expect of the other while providing legal services for older individuals throughout the PSA. This agreement shall be updated periodically, as needed.

15. Coordinate with area providers of case management and long-term care ombudsman services by developing, formally or informally, a memorandum of understanding that includes, but is not limited to, conflict of interest, case acceptance, and referral procedures.

16. Develop and follow a program policy and protocol for referral of fee generating cases and conflicts of interest and submit to the AAA for approval.

17. Encourage involvement of the private bar in legal assistance activities, including groups within the private bar furnishing services to older individuals on a pro bono or reduced fee basis, and coordinate these efforts with those undertaken by the AAA.

18. Obtain and maintain a signed representation/service agreement in the file of each client for whom OAATitle III-B legal representation is provided and keep for a minimum of five (5) years after termination of client representation.

19. Have a written policy and protocol that requires staff to provide information to clients, during initial contact, outlining clients' rights of appeal and describing the AAA grievance procedures.

20. Provide legal assistance for elderly individuals with visual impairments, hearing impairments, and language barriers, as needed, including written materials in alternative formats.

6.3.4.B (cont.)

21. Communicate with the AAA regarding overall operation and development of the AAA's legal programs insofar as the potential to impact older individuals.

22. Submit semi-annual reports, (KDADS Form SS-028, Legal Services Reporting Form) to the AAA as required by contract.

23. Respond to reasonable requests from the AAA and/or KDADS's Legal Service Developer, in a timely manner, for information or reports on local trends or legal issues affecting older individuals.

TABLE OF CONTENTS

SECTION 7: AAA OPERATING POLICIES AND PROCEDURES

7.1 Area Plans

7.1.1 Public Hearing Requirements
7.1.2 Adequate Proportion
7.1.3 Direct Service Waivers
7.1.4 Area Plan Revisions
7.1.5 OAA Intrastate Funding Formula
7.1.6 Funds for Reallocation of OAA Unearned Funds
7.1.7 Limitations on Budget and Expenditures

7.1 Area Plans

According to Section 306 of the Older Americans Act (OAA), each Area Agency on Aging (AAA) shall develop an area plan that is approved by the Kansas Department for Aging and Disability Services (KDADS) for a period designated by KDADS, with such annual adjustments or revisions as may be necessary.

7.1.1 Public Hearing Requirements

A. Each AAA must hold, at a minimum, one (1) public hearing on its area plan, and one (1) public hearing for each area plan update. The hearing must be held before the plan or update is submitted to KDADS for approval.

B. The AAA must provide a minimum of five (5) days written notice of the hearing.

C. The notice must include the hearing date, time, location, and purposes and shall be published in the largest newspaper of general circulation within the applicable locality at least five (5) days prior to the hearing date. Interested persons who have requested to be notified of the hearings must be provided a copy of the written notice. As deemed necessary by the AAA to ensure adequate input on the area plan, copies of the written notice may be sent to providers and advocacy agencies that serve older adults.

D. The AAA must maintain a written record of how notice was given and a record of the hearing.

7.1.2 Adequate Proportion

A. Each AAA shall assure that an adequate proportion of the amount allocated to their agency for OAA Title III B and OAA III E is budgeted and expended for the delivery of each of the following categories of service:

1. OAA III B
   i. Access;
   ii. In-home services; and
   iii. Legal Assistance
2. OAA III E
   i. Respite;
   ii. Information;
   iii. Assistance;
   iv. Support Groups; and
   v. Supplemental Services

7.1.2 (cont.)

B. Adequate proportion of the OAA Title III B and the OAA Title III E allocation is thirty-nine percent (39%) of the amount allocated to the AAA for a fiscal year. Of these percentages, the AAA shall budget and expend for each of the services as follows:

Service	Funding Source	Minimum Percentage
Access	OAA III B	9%
In-home	OAA III B	20%
Legal	OAA III B	5%
Any one or a combination of the service categories listed above	OAA III B	5%
Total	OAA III B	39%

Service	Funding Source	Minimum Percentage
Information	OAA III E	7%
Assistance	OAA III E	7%
Support Groups	OAA III E	5%
Respite	OAA III E	15%
Supplemental Services	OAA III E	5%
Total	OAA III E	39%

C. The AAA shall determine the amount to budget and expend on the remaining OAA III B adequate proportion amount of five percent (5%) to any one or a combination of the three services of access, in-home, and/or legal.

D. Adequate proportion for OAA III E services can be a combination of services for either/or caregivers or grandparents. The total combination must equal minimum percentage for services.

7.1.3 Direct Service Waivers

A. Eligible Services

The AAA may only provide OAA supportive services, nutrition services, or in-home services directly to program customers, in lieu of contracting or granting with another entity to provide such services, in accordance with OAA Section 307(a)(8) when any of the following conditions are met:

1. It is necessary to assure an adequate supply of such services;

7.1.3.A (cont.)

2. Services are directly related to the AAA's administrative functions; or

3. Services of comparable quality can be provided more economically by an AAA.

B. Waiver Requests

There are two types of requests for waivers that will be accepted by KDADS.

1. Request to Provide Services Directly Related to AAA Administrative Functions

This type of request shall be made in the transmittal letter that accompanies the initial area plan, an area plan update, or an area plan revision. The transmittal letter shall include the page number in the area plan referencing the service the AAA would like to provide directly. The transmittal letter shall be sent to KDADS's Area Plan Coordinator.

The following services are considered related to the AAA's administrative functions:

Title III B • Advocacy/Representation • Assessment • Case Management • Coordination • Education/Training • Information and Assistance • Interpreting/Translation • Newsletter • Outreach • Public Education • Placement • Program Development **Title III C** • Nutrition Outreach	**Title III D** • Coordination of Community Mental Health Services • Counseling Regarding Social Services and Follow-Up Services • Home Injury Control Educational Services • Home Injury Control Screening Services • Information- Age Related Disorders • Medication Management Education • Provision of Education Activities for the Prevention of Depression **Title III E** • Information • Assistance

2. Request to Provide Services Not Directly Related to AAA Administrative Functions

This type of request shall be made by submitting the Direct Service Waiver Request form (KDADS 200-2) for all non-administrative services listed on the aging services taxonomy when direct provision of services is:

7.1.3.B.2 (cont.)

a. Necessary to assure an adequate supply of such services; or

b. The AAA can provide services of comparable quality more economically.

3. The form shall be included in the initial area plan, an area plan update, or an area plan revision and placed between the application and verification of application. The form and transmittal letter shall be sent to KDADS's Area Plan Coordinator.

C. Waiver Determination

1. Only the Secretary has the authority to grant a direct service waiver to the AAA.

D. Duration of Waiver(s)

1. If the waiver request is submitted with the initial area plan, the waiver will be in effect for the duration of the plan.

2. If the request is submitted with an annual update, the waiver will be in effect for the remainder of the update of the plan, whichever is requested.

3. A waiver may also be granted for any portion of the fiscal year(s) in which it is submitted.

7.1.4 Area Plan Revisions

A. A revision request(s) must be submitted on the standard area plan format when one or more of the following occur:

1. An addition or deletion of a program objective;

2. An increase or decrease of 20% or more in the number of units or cost of each service budgeted in OAA Title III B (except for services in the In-Home and Access Services categories), III C1, III C2, III D, and III E (except services in the Supplemental Services Category) (see taxonomy for service definition and unit of service);

3. An increase or decrease of 20% or more in the total number of units or cost budgeted for Title III B In-Home and Access service categories and Title III E Supplemental Services category;

4. A transfer of funds between OAA III C1 and III C2;

7.1.4.A (cont.)

5. An addition or deletion to capital expenditures including equipment, buildings, and renovation;

6. An application for a direct service waiver; or

7. An application for program development or coordination services funds.

B. KDADS will not approve area plan revisions that prevent the AAA from meeting the matching and service funding requirements prescribed in applicable policy.

C. Transmittal letters indicating the date of the Governing body's approval must accompany area plan revisions.

D. Area Plan Revisions must include all requested information outlined in Area Plan Instructions issued for corresponding fiscal year in order to be considered for a revision of the Area Plan.

7.1.5 OAA Intrastate Funding Formula

A. Base Allocation

1. A base allocation of $150,000 is allotted to each planning and service area (PSA) from the OAA III B social services allotment. This base allocation takes into consideration the special needs of the rural PSAs and ensures viable funding across the entire state.

B. Remaining Allotment

1. The remaining OAA III B social service, OAA III C nutrition services, OAA III D health promotion and disease prevention, OAA III E the National Family Caregiver Support Program, and any future allocation under Title III shall be allotted using the following method:

2. Using best available data, each PSA shall be allotted an amount based on 40% of the population age 60 and older, plus 40% of the low-income population age 60 and older, plus 10% of the minority population age 60 and older, plus 10% of the population age 75 and older in the PSA.

OR

(Formula found on following page)

7.1.5.B.2 (cont.)

[(40%A) + (40%B) + (10%C) + (10%D)] / [(40%E) + (40%F) + (10%G) + (10%H)] = PSA allocation percentage

A = PSA's age 60 and older population	E = State's age 60 and older population
B = PSA's low-income population age 60 and older	F = State's low-income population age 60 and older population
C = PSA's minority population age 60 and older	G = State's minority population age 60 and older
D = PSA's age 75 and older population	H = State's age 75 and older population

3. The low-income population consists of the number of persons with incomes at or below poverty level as established by the Census Bureau.

7.1.6 Funds for Reallocation of OAA Unearned Funds

A. If the amount of the unearned OAA funds, excluding Administrative funds, is not more than five (5) percent of the AAA's total federal award, then the entire amount of the unearned federal funds shall be retained by the AAA.

B. If the amount of unearned OAA funds is more than five percent of the AAA's total award, then:

1. An amount of the OAA unearned funds equal to five percent of the AAA's award shall be retained by the AAA; and

2. Remaining unearned funds shall be pooled, reduced by an amount designated for special or model projects, and if a balance remains, those funds will be allocated to the AAAs that had unearned funds of five percent or less, using the intrastate funding formula adjusted by excluding those AAAs that had unearned funds in excess of five percent of their award.

7.1.7 Limitations on Budget and Expenditures

A. The AAA shall budget and expend its total AAA administrative allotment before the AAA can earn any OAA III B funds for coordination and/or program development.

KANSAS DEPARTMENT ON AGING
FIELD SERVICES MANUAL

TABLE OF CONTENTS
SECTION 8: FISCAL POLICY

8.1 Financial Management - Older Americans Act Funds

8.1.1 Financial Management and Reporting Requirements
8.1.2 Regulatory Authorities
8.1.3 Notification of Grant Awards (NGA)
8.1.4 Cash Disbursements for Grant Funding
8.1.5 Interest Earned on Federal Advances
8.1.6 Financial Management
8.1.7 OAA Title III Financial Report Requirements
8.1.8 Enforcement Action
8.1.9 Appeals

8.2 Financial Management - KDOA Contracts and Special Grants *(Under Development)*

8.1.1 Financial Management and Reporting Requirements

Financial management requirements consist of accurate, current, and complete disclosure of the financial results of each program funded, in whole or in part, by Federal and/or State funds provided by the Kansas Department for Aging and Disability Services (KDADS). Requirements include maintenance of an effective financial management system, budget approvals, establishing fund availability, satisfaction of matching requirements, accounting for program income, determining allowability of costs, methods for making payments to providers of services, and meeting Federal and State audit requirements.

Recipients of programs funded by KDADS are required to meet the applicable Federal and State standards and requirements for financial management systems set forth below:

8.1.2 Regulatory Authorities

A. The Older Americans Act of 1965, as amended, and codified at 42 U.S.C. Section 3001, et seq.;

B. The following regulatory authorities are applicable to units of local governments:
   1. Grants to State and Community Programs on Aging - 45 CFR Part 1321
   2. Uniform Administrative Requirements for Grants to State and Local Governments - 45 CFR Part 92
   3. Cost Principles - 2 CFR Part 225
   4. Administrative Requirements - OMB Circular A-102
   5. Audit Requirements - OMB Circular A-133

C. The following regulatory authorities are applicable to non-profit organizations:
   1. Grants to State and Community Programs on Aging - 45 CFR Part 1321
   2. Uniform Administrative Requirements for Awards and Subawards - 45 CFR Part 74
   3. Cost Principles - 2 CFR Part 230
   4. Administrative Requirements - 2 CFR Part 215
   5. Audit Requirements - OMB Circular A-133

8.1.3 Notification of Grant Awards (NGA)

The NGA is the legal document issued to the grantee that indicates that an award has been made and that funds may be requested from KDADS.

A. KDADS will issue a sequentially numbered Notification of Grant Award (aka “NGA” or “Grant”) based on the grantee area plan budget submitted to and approved by KDADS.

B. The NGA will contain the terms and conditions of the award that are required in addition to the provisions contained in the grantee application.

8.1.3 (cont)

C. NGA's must be signed by an authorized official of the grantee organization and returned to KDADS in order to become effective. Until KDADS issues and receives a signed NGA for the initial budget period, any costs incurred by the grantee for the project period are incurred at the grantee's own risk. Funds will not be advanced from a grant award without an NGA signed by the secretary and authorized grantee official.

D. NGA's issued as "Revision" or "Carryover" and following a sequential order will replace the existing grant award, which becomes obsolete on the effective date of the revised NGA. Contents, terms and conditions of the NGA are binding on the recipient unless and until modified by a revised NGA signed by the secretary and authorized grantee official.

E. In making a subgrant or contract, each grantee or contractor shall use the funds awarded under a KDADS-approved area plan for those services that are consistent with service definitions issued and provided by KDADS and the identified priority service needs for the planning and service area (PSA).

F. Each grantee or contractor funded in whole or in part by KDADS shall comply with the Federal and State financial requirements applicable to providers of services funded.

8.1.4 Cash Disbursements for Grant Funding

A. Cash may be requested after KDADS receipt of a signed NGA from the grantee. Recipients of a KDADS grant must complete KDADS Cash Request form and submit to KDADS to request grant funds.

B. Cash requests must be signed by an authorized official of the recipient organization and dated.

C. Cash requests should be submitted on a monthly basis to fund current expenditures and obligations and to minimize the time elapsing between the transfer of funds from KDADS to the recipient organization and the subsequent payment of obligations incurred as a result of the award. Payment for approved requests received by KDADS on or before the 20th of the month will typically be processed and submitted to the grantor by the first week of the following month.

D. Grantees will be paid in advance, provided regulatory compliance and the terms and conditions of the grant are maintained. Non-compliance of regulatory requirements or failure to comply with the terms and conditions of the grant award may result in KDADS holding of funds until compliance is attained.

E. If the grantee has excess cash-on-hand at the end of the fiscal year, which is cash advanced in excess of what is earned, KDADS may require the grantee to return the funds or the money will be considered Cash on Hand for the following grant period.

8.1.5 Interest Earned on Federal Advances

A. Non-Profit (Non-governmental) Recipients

1. Recipients must maintain advances of Federal funds in interest bearing accounts unless one of the following conditions apply:

    a. The recipient receives less than $120,000 in Federal funds per year;
    b. The best reasonably available interest bearing account would not be expected to earn interest in excess of $250 per year on Federal cash balances;
    c. The depository would require an average or minimum balance so high that it would not be feasible within the expected Federal and non-Federal cash resources.

2. Interest earned on Federal funds in amounts up to $250 per year may be retained by the recipient for administrative expenses.

3. Interest earned on Federal funds in excess of $250 per year must be remitted annually to the Department of Health and Human Services, Payment Management System.

B. Local Government Recipients

1. Local governmental recipients may retain interest earned on Federal funds in amounts up to $100 per year for administrative expenses.

2. Interest earned on Federal funds in excess of $100 per year must be remitted annually to the Department of Health and Human Services, Payment Management System.

8.1.6 Financial Management

Each grantee is solely responsible for obtaining and reporting necessary information from subgrantees, contractors, and subcontractors with whom the grantee has subgrants, contracts, or subcontracts.

A. Receipts

1. Funding sources include the following categories:
    a. Program Income;
    b. Mill Levy;
    c. Other Cash;
    d. Third party In-kind;
    e. State General Funds;

8.1.6.A.1 (cont.)

f. Federal Funds (by OAA Program and Nutrition Services Incentive Program (NSIP)); and
g. Nutrition Check-off.

2. Match shall be earned and reported as Mill Levy, Other Cash, State General Funds, and/or Third party In-kind.

3. Receipts must be reported on a cash basis. Total year-to-date receipts must equal the ending balance from the previous month plus the amount reported as received during the current report month.

4. Match Funds requirements are as follows:

   a. Expenditures under an approved budget that consists of both Federal and non-Federal shares are deemed to be borne by the recipient in the same proportion as the percentage of Federal/non-Federal participation in the overall budget.

   b. To be accepted, all matching contributions, including cash and third party in-kind, shall meet all of the following criteria:

      i. Are verifiable from the grantee's or the subrecipient's records;
      ii. Are not included as contributions for any other federally-assisted project or program;
      iii. Are necessary and reasonable for proper and efficient accomplishment of project or program objectives;
      iv. Are allowable under the applicable cost principles;
      v. Are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for matching; and
      vi. Are provided for in the approved budget.

   c. Excess local cash match and/or mill levy match may be substituted for shortages in third party in-kind match.

   d. Third party in-kind match may not be used to substitute for a shortage in local cash match and/or mill levy match.

5. Program income must be reported and used for expansion of services in accordance with OAA Section 315(b)(4)(E).

   a. Service providers are required to provide an opportunity to individuals being served under Title III service programs to make voluntary contributions for services received.

8.1.6.A.5 (cont.)

b. Voluntary contributions received by service providers from program customers must be reported as "Program Income - Non-Match" in the Federal fiscal year in which they are received.

B. Grant Expenses

1. Actual expenses must be charged to the program or grant for costs incurred by a provider of service that directly relate to administering the program. Depreciation expenses, use allowances, lobbying, and fundraising are unallowable costs. Vehicle purchases under OAA Titles III-B, III-D, and III-E are unallowable costs.

2. Expenditures are reported for the month in which they are paid and accumulated year-to-date. The year-to-date balance from the preceding month plus expenditures for the current month must balance to the year-to-date total or a revised report is required. Obligations incurred but not paid are reported separately.

3. The grantee must use the "first-in/first-out" principle for recognizing and recording obligations and expenditures of grant funds.

4. The AAA must expend its total OAATitle III Area Agency Administration award before federal funds for OAATitle III-B Program Development and/or Coordination services can be earned.

   a. If the AAA does not expend its total Administration award, expenditures for OAATitle III B Program Development and/or Coordination activities should be re-classified as Administrative Costs in an amount sufficient for the AAA to expend 100% of its Administration award.

   b. Costs re-classified as Administrative Costs must have sufficient match (25%) to meet OAA requirements, and 25% of the local cash match requirement for OAA programs must come from public funds.

5. Any service category or line item expenditure reported that exceeds 20% of the budgeted amount on which the final NGA was based are unallowable for the grant period.

6. Program income, including customer contributions, shall be expended before Federal funds are earned.

7. If unallowable expenditures are reported, the grantee is at risk of losing federal and state funds through the carryover and audit process.

8.1.6 (cont.)

C. Transfer Policy Between OAATitles III C(1) and C(2)

1. The AAA may transfer up to 40% of the Title III-C(1) and C(2) funds allocated for the respective congregate and home delivered meals programs.

2. The AAA must receive prior written approval from the Secretary if there is a need for transferring more than 40% to ensure the state meets federal regulatory compliance of a maximum 40% transfer statewide.

D. OAA Priority Services

1. Adequate Proportion expenditure requirements for Title III-B and Title III E must be expended for Access, In-Home, and Legal Services (Title III B) and Respite (Title III E) according to the percentages specified in Section 7.1.2.B.

2. Should the AAA not meet its Adequate Proportion spending requirements during the fiscal year, the unexpended Adequate Proportion for that fiscal year will be added to the subsequent fiscal year's requirement and specified on the AAA's Title III-B and/or Title III E NGA.

E. Unearned OAA Funds (Carryover Process):

The carryover process entails a total audit of the AAA's final financial reports and supporting documentation to ensure compliance with all state and federal regulations. Information to be reviewed during the carryover process includes the following:

1. Adequate Proportion requirements are met;
2. The budget on the financial report matches the approved award per the final NGA for the project period;
3. The Federal, state, and nutrition check-off funds drawn are reported as receipts;
4. The NSIP cash and entitlements reported as receipts matches what was disbursed to the AAA and/or the provider during the project period;
5. The provider contract and/or grant reports equals the amounts reported on the AAA financial report;
6. The amounts on the front and back of the financial report match;
7. The match ratio reported is in compliance (equals) the match required to earn federal funds per the approved NGA.
    a. Third Party In-Kind match reported cannot exceed the percent of Third Party In-Kind match required on the back of the NGA.
    b. Third Party In-Kind match cannot be substituted for other local cash match; however, other local cash match can be substituted for Third Party In-Kind match;

8.1.6.E (cont.)

8. All Program Income reported as received is also reported expended;

9. All non-match funds reported as received are reported as expended;
10. Total line item and service category expenditures do not exceed 20% of the budgeted line item or service category amounts (See Section 7.1.4);
11. All AAA Administration funds awarded are expended in the project period. If the AAA Administration funds awarded are not expended, the AAA should transfer the amount of the shortage plus adequate match from III-B program development and/or coordination to AAA Administration. (Note: the required percent of match on AAA Administration is higher than what is required for III-B which could result in a shortage in match for III-B); and
12. All other requirements or conditions on the back of the NGA for the grant period are met.

F. Ending Cash Balances

1. Federal cash on hand should be limited to the minimum amounts needed and cash requests timed to be in accordance with the actual, immediate cash requirements of the grantee in carrying out the purpose of the approved program or project. The timing and amount of cash advances shall be as close as is administratively feasible to the actual disbursements by the grantee for direct program or project costs and the proportionate share of any allowable indirect costs.

2. KDADS shall use each grantee's monthly financial report to monitor Federal and state cash advanced and to obtain disbursement information for each grant with the grantee.

8.1.7 OAA Title III Financial Report Requirements

A. The AAA is required to submit financial reports to KDADS to comply with Federal and State reporting requirements. The AAA shall be responsible for gathering accurate information necessary to complete the following reports within the specified timeframes:

1. The KDADS Financial Report Forms shall be completed monthly and submitted to KDADS on or before the 20th of the month following the reporting period.

2. The final Financial Report and supporting documentation is due to KDADS on or before December 15th following the end of the September 30th grant period (KAR 26-2-3). This report will revise the September 30th report, thereby providing an accurate accounting for the fiscal year.

8.1.7.A (cont.)

3. If a final revised financial report is not received by December 31st following the end of the federal fiscal year, the most recent financial report submitted for the fiscal year will be considered the final report.

B. Before submitting the final financial report, the grantee shall liquidate all obligations for all goods and services for the report period. The final report must have no unliquidated obligations and shall reflect the exact balance of unobligated funds.

C. It is the AAA's responsibility to reconcile subgrantee, contractor, and subcontractor reports that are received by the AAA as supporting documentation for the area agency final financial reports.

D. The AAA shall submit a consolidated final financial report to KDADS for each program component and shall include a summarized report, certified by the AAA Executive Director, listing the program's receipts and expenditures as reported by each subgrantee, contractor, and subcontractor that supports the AAA's final financial report on the following forms:

1. Administration - KDADS Form 312
2. Title III-B Supportive Services – KDADS Form 328
3. Title III-C(1) Congregate Meals – KDADS Form 329
4. Title III-C(2) Home Delivered Nutrition Services – KDADS Form 330
5. Title III-D Disease Prevention and Health Promotion Services – KDADS Form 331
6. Title III-E Caregivers – KDADS Form 332
7. AAA Direct Service Report - KDADS 338 (optional)

E. An area agency may submit a revised final financial report only if the report is accompanied by the supporting final financial report for each of the AAA's OAA Title III subgrantees, contractors, and subcontractors and the following conditions are met:

1. The final report was received on or before December 15th following the grant period (KAR 26-2-3);

2. A revised final report, if required, is received on or before December 31st following the grant period; and

3. The revised final report is received on or before April 15th, and the report is delivered simultaneously with the audit report performed in accordance with KAR 26-2-9 confirming that the revised report is an accurate report.

8.1.7 (cont.)

F. All financial reports and cash requests shall be submitted in the manner prescribed by KDADS. KDADS may accept the identical information from the grantee in electronic outputs in lieu of prescribed formats, provided the document is legible and reflects the signature of an authorized official.

G. Failure to submit required reports within the time allowed may result in the withholding of advances or other penalties as prescribed in KAR 26-2-6 and FSM Section 8.1.8.

H. A waiver of deadline for submitting a required financial report may be considered by the secretary if all of the following requirements are met:

1. The grantee submits a written request signed by the authorized official to KDADS to be received at least eight business days before the due date for the report for which the waiver is being requested;

2. The written request provides an acceptable reason for the reporting delay and is legitimately beyond the grantee's control;

3. An acceptable remediation for the cause of the delay is provided; and

4. A revised report is received by the revised due date indicated in the request.

I. Within five business days after receipt of the written waiver request, a written notice of denial or approval of the request shall be issued by the secretary. The deadline for submitting a program or financial report shall not be deemed changed merely because the grantee submitted a written waiver request for an extension of the report's due date.

8.1.8 Enforcement Action

A. If a grantee fails to comply with the terms and conditions of an award, regardless whether such terms and/or conditions are stated in statute, regulation, policy, application, or an NGA, KDADS may take appropriate action, including one or more of the following:

1. Withhold payments to the grantee if the grantee fails to submit any document required by KDADS on or before the established due date;

2. Withhold payments to the grantee if expenditures by the grantee fails to comply with applicable Federal or State requirements;

3. Withhold payments to the grantee if the secretary suspends or terminates the grant or contract;

8.1.8.A (cont.)

4. Disallow all or part of the cost of the activity not in compliance, including use of Federal or State funds and any applicable matching credit;

5. Wholly or partly suspend or terminate the current award;

6. Withhold further awards for the project or program; and

7. Utilize any and all other remedies available under applicable law, or as authorized by the secretary.

B. If KDADS takes an enforcement action, the grantee may appeal the same. (See Section 8.1.9)

8.1.9 Appeals

A. Area agencies may appeal non-Medicaid adverse actions taken by KDADS. (See KAR 26-4-1 et seq.) By way of example, and without limitation, an area agency may appeal the following adverse actions:

1. Termination, in whole or in part, of a grant for failure of the AAA to:

   a. carry out its approved project in accordance with the applicable law and the terms and conditions of the award; or

   b. comply with any law, regulation, assurance, term, or condition applicable to the grant;

2. Determination that an expenditure has been improperly charged to the grant or that the AAA has otherwise failed to discharge its obligation to account for grant funds;

3. With the exception of federal debarment, withholding or denial of a non-competing continuation award for failure to comply with the terms of a previous award;

4. Determination that a grant is void (i.e. a decision that an award is invalid because it was not authorized by statute or regulation or because it was fraudulently obtained); or

5. Any other adverse action taken by KDADS.

B. If KDADS intends to take an adverse action, written notice of the same will be provided, which notice shall contain the AAA's appeal rights (KAR 26-4-1).

8.1.9 (cont.)

C. The AAA must submit a written request for review within 33 days after receiving written notice of action, detailing the nature of the disagreement with the adverse determination and providing supporting documents in accordance with the procedures contained in the notification. The written request must be sent to the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, KS 66612 (KSA 75-37,121).

D. KDADS encourages each AAA to try to resolve disputes by using alternative dispute resolution (ADR) techniques, which is often effective in reducing the cost, delay, and contentiousness involved in appeals and other traditional ways of handling disputes. Provided, however, that such ADR shall not toll the time in which the AAA may file an appeal (KAR 26-4-6).

E. If an appeal is filed, it will be governed by the process set forth in KAR 26-4-7 through KAR 26-4-15.

8.2 AAA and Other Providers Policy

8.2.1 Signature Authority

A. The department shall not accept any document signed by an organization unless the organization has provided reasonable evidence indicating that the person signing such document on behalf of the organization was authorized to execute the same.

B. On or before May 1st of each year, an organization shall provide to the department reliable evidence from the organization's governing body indicating who has the authority to sign documents on behalf of the organization.

1. "Reliable evidence" means:

- A notarized affidavit of the Chairperson of the governing board; or
- A resolution of the governing body which was adopted at a meeting of that governing body and included in a certified copy of the official minutes of that meeting (certified by the secretary of the governing body); or
- A resolution of the governing body adopted at a meeting of the governing body, which appears in the form of a certified copy of the resolution only (certified by the secretary of the governing body); or
- A resolution of the governing body which is adopted through a "consent to action" instead of at a meeting of the governing body, which resolution is included in the "consent minutes" signed by all of the members of the governing body.

2. Each submitted form of "reliable evidence" of authorization:

- Shall clearly and affirmatively record the governing body's authorization;
- Shall clearly identify the person(s) or position(s) designated and authorized to sign. If such reliable evidence only lists the title or position, the governing body must also submit a letter indicating the names of the persons presently in such position(s) and, must update the same should there be a change in such title or position;
- Shall clearly identify which documents the designated persons are authorized to sign; and
- Shall include some indication that the authorization remains in full force and effect from a specified date forward.

KANSAS DEPARTMENT ON AGING
FIELD SERVICES MANUAL

TABLE OF CONTENTS
SECTION 9: MISCELLANEOUS POLICIES

9.1 Automated Billing Process

9.2 Signature Authority

9.3 Record Retention and Access *(Under Development)*

9.4 Audit Requirements *(Under Development)*

9 Miscellaneous Provider Policy

9.1 Automated Billing Process

A. The Kansas Department on Aging's (KDOA's) contract terms with each provider specify due dates for required data entry into the Kansas Aging Management Information System (KAMIS). When due dates for data entry are not specified, the provider must enter its bill for services delivered during any one month into KAMIS in the subsequent month on or before the following due dates:

1. The 10th for CARE Program Assessments;

2. The 15th for Targeted Case Management (TCM)/state general funds; and

3. The 24th for state funded (e.g. Senior Care Act (SCA), Older Americans Act (OAA), and Nutrition Services Incentive Program (NSIP)) funded services.

B. No payment shall be made for units of service entered greater than two (2) months following the original billing deadline.

C. The final deadline for services provided during the month of June is August 24th unless otherwise specified in the contract. A contractor or sub-grantee that enters data into KAMIS after this deadline will not receive payment for services.

D. KDOA will make adjustments for previously paid services according to the following terms and conditions:

1. If the adjustment is the result of an overpayment from KDOA, the financial adjustment shall be made regardless of the period in which the overpayment occurred.

2. The provider must have initially entered plan of care data and units of service into KAMIS by the deadlines specified in Sections 2.6.2.M and 9.1.A through 9.1.C.

3. A retroactive financial adjustment will only be made if entered within two (2) months following the original billing deadline specified above, and under no circumstances will a retroactive adjustment be made for any state fiscal year (SFY) if entered into KAMIS after August 24th following the end of the SFY services were provided, unless the adjustment is the result of a KDOA overpayment.

E. If bills for services are submitted timely, KDOA will pay those bills within the following calendar month.

9.2 Signature Authority

A. KDOA shall not accept any document signed by an organization unless the organization has provided reasonable evidence indicating that the person signing such document on behalf of the organization was authorized to execute the same.

B. On or before May 1st of each year, an organization shall provide to KDOA (Attention: Director, Accounting and Financial Management Division) reliable evidence from the organization's governing body indicating who has the authority to sign documents on behalf of the organization.

1. "Reliable evidence" means:

    a. A notarized affidavit of the Chairperson of the governing board; or

    b. A resolution of the governing body which was adopted at a meeting of that governing body and included in a certified copy of the official minutes of that meeting (certified by the secretary of the governing body); or

    c. A resolution of the governing body adopted at a meeting of the governing body, which appears in the form of a certified copy of the resolution only (certified by the secretary of the governing body); or

    d. A resolution of the governing body which is adopted through a "consent to action" instead of at a meeting of the governing body, which resolution is included in the "consent minutes" signed by all of the members of the governing body.

2. Each submitted form of "reliable evidence" of authorization:

    a. Shall clearly and affirmatively record the governing body's authorization;

    b. Shall clearly identify the person(s) or position(s) designated and authorized to sign. If such reliable evidence only lists the title or position, the governing body must also submit a letter indicating the names of the persons presently in such position(s) and, must update the same should there be a change in such title or position;

    c. Shall clearly identify which documents the designated persons are authorized to sign; and

    d. Shall include some indication that the authorization remains in full force and effect from a specified date forward.