APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Kansas

B. Waiver Title(s): Autism; Brain Injury, Frail Elderly, Intellectual & Developmental Disability; Physical Disability; Serious Emotional Disturbance; Technology Assisted

C. Control Number(s):

- 0476.R02.02
- 4164.R06.03
- 0303.R04.03
- 0224.R06.03
- 0320.R04.03
- 4165.R06.02
- 0304.R04.03

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected

changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: January 27, 2020 **Anticipated End Date:** January 26, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.__X_ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii._X__ Temporarily modify additional targeting criteria.

[Explanation of changes]

The requirement the participant must receive at least one service every 30 days is modified to: If a participant receives services less than monthly, then the participant requires regular monthly monitoring.

b.__X_ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. X___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

Allow Personal Care Services to more than one individual at a time and in a group setting as long as billing time is divided to reflect the amount of time rendered to each individual. Allow Respite to more than one individual at a time and in a group setting as long as billing is divided to reflect the amount of time rendered to each individual.

iii. _X__Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. __X_Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

Day Support Services: The State will allow Day Support services to be provided wherever a participant authorized to receive such services is located.

Participants may receive services while living with a paid caregiver; Participants may receive services while living in a temporary family or other home including hotels or crisis housing; I/DD and BI participants may receive services in an assisted living, group home, or home plus setting; I/DD participants may receive day services provided in a home setting wherever the participant is residing.

Respite Services: Respite services may include respite provided in a facility-based setting. In a facility-based setting, room and board are excluded. Such settings include hotels or crisis housing as well as assisted living, group home, or home plus setting.

Day Support and/or Respite Service will be provided to a participant in any location in which they are residing.

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d._X__ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i._X__ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Allow relatives of waiver beneficiaries who reside in the home and out of the home to provide services prior to background check and training for 90 days. It is understood that the background check will be submitted by the agency within 30 days after the service begins and training will occur within 90 days of hire without leaving the beneficiary without necessary care.
The state is modifying provider standards for relatives to qualify as a direct worker while his/her background check and pre-employment screenings are in pending status. This allowance will be applied to both traditional and participant-directed service (PDS) arrangements. Further, should a pending screening come back demonstrating concerns with the background check and/or pre-employment screening that would not allow the worker to continue employment long term that worker continues to be qualified until an alternative employee is identified unless the worker poses an immediate jeopardy to health, safety, and/or welfare of the participant (i.e. has tested positive for infectious disease) or is found to be guilty of past abuse, neglect, exploitation or violent felony and therefore is immediately unqualified.

Suspend training requirements for immediate family members and/or legal representatives providing services to waiver participants. As defined by the IRS, "immediate family member" includes a spouse, child, parent, grandparent, brother, sister, grandchild, stepparent, stepchild, stepbrother or stepsister of the participant.

CPR/First Aide training will be allowed to be completed online rather than in person.

ii._X__ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

In the event that there is no Specialized Medical Care provider available to a waiver participant, the Managed Care Organization is authorized to pay Personal Care Services (PCS) in lieu of this service. This exception includes paying parents and family as PCS workers. We will allow for any hours not covered under the Specialized Medical Care due to lack of providers to be covered by Personal Care Services. Personal Care Services will substitute for Specialized Medical Care.

The state will allow payment to family caregivers or legally responsible individuals, suspending the conflict of interest mitigation for PCS. We are referring to state identified COI for Guardians and DPOAs.

These services may be delivered in a person's home or a temporary setting, including a family member's home.

iii.__X_ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

For temporary staff or for services delivered in temporary settings, the requirement to utilize the electronic check in and check out function of the state's Electronic Visit Verification System is not required. In such instances, paper timesheets may be submitted to the employing agency or to the Financial Management Services provider for billing.

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h._x__ Temporarily modify incident reporting requirements, medication management or other

participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

Kansas will submit with a nine-month delay 372 reports for 0304.R04.03 PD, 0303.R04.03 FE due 6/30/2020, and 0320.R04.03 SED due 9/30/2020. Kansas requests a three-month extension for 0224.R06.03 I/DD and 4164.R06.03 BI due 12/31/2020.

Kansas will submit with a nine-month delay evidence packages for 0320.R04.03 SED, 0476.R02.02 Autism due 6/30/2020 and 4165.R06.02 TA due 10/30/2020.

During this crisis, Kansas resources are focused on our COVID-19 response and we will need more time to address these reports and packages once the crisis has passed.

i._X__ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

Personal Care Services and/or Enhanced Care Services may be paid for no more than 30 consecutive days.

j.___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
    a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**
    a. ☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
        i. ☒ Case management

ii. ☒ Personal care services that only require verbal cueing
iii. ☒ In-home habilitation
iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
v. ☒ Other *[Describe]:*

Day program services

b. ☒ Add home-delivered meals
c. ☒ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
d. ☒ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
   a. ☒ Current safeguards authorized in the approved waiver will apply to these entities.
   b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
   a. ☒ Allow spouses and parents of minor children to provide personal care services
   b. ☒ Allow a family member to be paid to render services to an individual.
   c. ☒ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

In the event that there is no Specialized Medical Care provider available to a Technology Assisted waiver participant, the Managed Care Organization is authorized to pay Personal Care Services (PCS) in lieu of this service. This exception includes paying parents and family as PCS workers.

   d. ☒ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**
   a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.
   b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
   c. ☒ Adjust prior approval/authorization elements approved in waiver.
   d. ☒ Adjust assessment requirements
   e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Bobbie
Last Name	Graff-Hendrixson
Title:	Director, Compliance and Contracting
Agency:	Kansas Department of Health & Environment, Division of Health Care Finance
Address 1:	900 S Jackson Ave, Suite 900N
Address 2:	Click or tap here to enter text.
City	Topeka
State	KS
Zip Code	66612
Telephone:	785.296-0149
E-mail	Bobbie.Graff-Hendrixson@ks.gov
Fax Number	785.296.3468

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Amy
Last Name	Penrod
Title:	Commissioner
Agency:	Kansas Department for Aging and Disability Services
Address 1:	503 S. Kansas Ave.
Address 2:	Click or tap here to enter text.
City	Topeka
State	KS
Zip Code	66603
Telephone:	785.296.0141
E-mail	Amy.Penrod1@ks.gov
Fax Number	785.296.0256

8. Authorizing Signature

Signature: **Date: 3/24/2020**

_____/S/_____
State Medicaid Director or Designee

First Name:	*Adam*
Last Name	*Proffitt*
Title:	State Medicaid Director
Agency:	Kansas Department of Health & Environment, Division of Health Care Finance
Address 1:	900 S Jackson Ave, Suite 900N
Address 2:	Click or tap here to enter text.
City	Topeka
State	Kansas
Zip Code	66612
Telephone:	785.296.3563
E-mail	Adam.Proffitt@ks.gov
Fax Number	785.296.3468

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Wellness Monitoring

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Wellness Monitoring is a process whereby a registered nurse evaluates the level of wellness of a participant to determine if the participant is properly using medical health services as recommended by a physician and if the health of the participant is sufficient to maintain him/her in the participant's place of residence without more frequent skilled nursing intervention.

Wellness Monitoring includes checking and/or monitoring the following:

1. Orientation to surroundings
2. Skin Characteristics
3. Edema
4. Personal Hygiene
5. Blood Pressure
6. Respiration
7. Pulse
8. Adjustments to medication

For members who access this service, the results will be included in information shared between the member's TCM and MCO care management staff.

The Registered Nurse providing the Wellness Monitoring will not also provide any services performed by a Personal Care Services provider to prevent duplicative billing with other services authorized on the Service Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Participants must have medical conditions that require monitoring if they are not receiving skilled nursing care.

Per the KanCare contracts the MCOs are responsible for ensuring the individual’s needs are met with a combination of waiver, State Plan and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

A participant eligible for wellness monitoring lives in a non-institutional setting and, through the utilization of wellness monitoring, is able to maintain his/her independence at home, or in an alternative living arrangement. This service is provided by Registered Nurses only, who may be employed by home health agencies licensed by the Department of Health and Environment, KDADS licensed agencies, public health departments or Community Service Providers.

To avoid overlap of services, Wellness Monitoring service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Direct medical intervention is obtained through the appropriate medical provider and is not funded by this program

Provider Specifications				
	☐	Individual. List types:	X	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		Registered Nurse employed by a licensed HHA or Public Health Department

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
	1.An RN licensed by the Kansas Board of Nursing consistent with K.S.A. 65-5101 through K.S.A.65-5117, AND 2.An employee of a Home Health Agency as specified in K.S.A. 65-5101 through K.S.A. 65-5117 OR 3.An employee of a Public Health Department		All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.
.			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.**	**The MCOs, with oversight by KDADS, shall verify provider qualifications annually.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Telehealth Monitoring
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Home telehealth is a remote monitoring system provided to a participant that enables the participant to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the participant's health declines. The provision of home telehealth entails participant education specific to one or more diseases (e.g. COPD, CHF, Hypertension, or Diabetes), counseling, and nursing supervision. Remote Monitoring Technology could include, but would not be limited to, cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation and/or touchscreen, vital sign telemonitoring mattress, web applications, or phone apps.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The provider will access the telehealth system to review each participant's baseline, defined by the participant's physician at enrollment and indicated in the Integrated Service Plan of Care, trended survey responses, and vital sign measurements. A licensed Registered Nurse will monitor the health status of multiple participant and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional. Telehealth services would be provided on an individualized basis for participants who have an identified need in their Integrated Service Plan of Care. Participant options/information would be provided and discussed during the development of the Service Plan. Monitoring would be initiated by the participant. Participants would have full control over the equipment to maintain their right to privacy. The participant will be trained on how to use designated equipment by the provider and/or equipment supplier. Equipment examples could include items such as a cardiac telemonitoring system, vital sign telemonitoring system with teleconsultation and/or touchscreen, vital sign telemonitoring mattress, web applications, phone apps, etc. The provider will access the telehealth system to review each participant's baseline, defined by the participant's physician at enrollment, trended survey responses, and vital sign measurements. A licensed Registered Nurse will monitor the health status of multiple participants and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				County Health Department; Medicare certified or KDHE licensed Home Health Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency	K.S.A. 65-5101 et seq. K.A.R. 28-51-100 et seq.		K.S.A. 65-201 et seq. K.A.R. 30-5-59 System equipment capable of monitoring customer vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature, and capable of asking the customer questions that are tailored to the customers diagnosis. The provider and equipment must have needed language options – e.g. English/Spanish/Russian/Vietnamese.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.**	**This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws,

regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:	Home Delivered Meals				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Home-Delivered Meals service provides a consumer with meals. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements. The meals are prepared elsewhere and delivered to a participant's residence.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
This service is limited to 2 meals a day to participants..					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Approved and Medicaid-enrolled nutrition provider agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
			Provider must have on staff or contract with a certified dietician to assure compliance with Kansas Department for Aging and Disability Services (KDADS) nutrition requirements for programs under the Older Americans Act.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**Managed Care Organizations in accordance with the Provider Qualification policy M2017-171.**	**The MCOs, with oversight by KDADS, shall verify provider qualifications annually.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Medical Supplies; Equipment & Appliances

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Purchase for Home or Vehicle modification is limited to a maximum lifetime expenditure of $ 7,500 per consumer, across all waivers except I/DD.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	General Contractor		Durable Medical Equipment provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Agency			As described in K.A.R. 30-5-59 • Medicaid-enrolled provider • Applicable work must be performed according to local and county codes
Individual			Must affiliate with a recognized Center for Independent Living or licensed home health agency (as defined in K.S.A. 65-5001 et seq.). • Applicable work must be performed according to local and county codes

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.**	**Kansas provides monitoring and oversight of MCO's verification of HCBS-PD provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Assistive technology means an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--
(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
applying, maintaining, repairing, or replacing assistive technology devices;
(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

LIMITATIONS:
• Assistive Technology is limited to the participant's assessed level of service need, as specified in the participant's Plan of Care, subject to an exception process established by the state. All participants are held to the same criteria when qualifying for an exception in accordance with the established KDADS policies and guidelines.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Any business, agency, or company that furnishes assistive technology items or services

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Agency	K.A.R. 129-5-108: "The Durable Medical Equipment [DME] shall be available to each beneficiary, with the following limitations: (1) The DME shall be the most econonomical to meet the beneficiary's need...(6) DME shall be covered for only the following types of beneficiaries: (A) Participants of the Kan Be Healthy program; (B) beneficiaries who require DME for life support; (C) beneficiaries who require DME for employment and; (D) beneficiaries who would require more expensive care if the DME was not provided."		K.A.R. 30-5-59 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.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	**Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs**	**This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed