PUBLIC COMMENTS FOR ALL WAIVER RENEWALS

AUGUST 2023

Waiver Amendment Changes				
#	**Sender**	**Page #**	**Changes/Recommendations**	**KDADS Response**
1	Minds Matter, Overland Park KS	30	It continues to be a concerns that the Physical Disabilty waiver doesn't allow for cognitive cuing. Many consumers transitioning from the BI waiver require this for effective transition.	Thank you for your comment. We will consider cognitive cuing for a PD Amendment.
		62	Why isn't virtual delivery of PCS available for conusmers choosing self-direction? Stays shorter than 90 days result I the need for more than 12 hours of PCS daily. Can this duration be shortened?	This is not available because we would require assurance that the PCS service is HIPAA and HITECH compliant.
		64	Need some clarification on the 2nd bullet where waiver funding may not be used to purchase devices or internet connectivity for the primary purpose of vitual deliver of care. Does this include funding received from the MCO?	Waiver funds cannot be used for internet or connectivity. The MCO may elect to use other funds for these services.
		68	Technology and Devices: 3rd bullet, add "where a new device is provided", the bullet says that the provider is responsible for maintenance, upkeep and assurance the device is in working order.	Thank you for your comment. We will take this under review.
		68	Why do we need to have multiple factors from the evaluation to be able to conduct therpy virtually in a bedroom/bathroom setting?	These areas of the home, and the tasks typically completed in them are very personal in nature. Without adequate service delivery assessment, agreement, and oversight the risk of exploitation is high. We are asking people to engage with us online, desensitizing participants to the use of camera's/online communication in areas we would otherwise say were restricted/off limits. While we would like to think that virtual services will always be secure, historically we have seen hackers and individuals with ill intent use the internet in illicit ways, and people who are vulnerable unknowingly fall prey to online predators. Every effort should be made to ensure we are using best practice and evaluating what the risks are, what can be gained, and plan to ensure we are protecting those who have entrusted us to recover from their brain injury.
		71	EPSDT wording in therapies remain concerning - technically consumers under 21 won't access waiver PT/OT/SLP. State plan employees don't have the expertise to work with pediatric BI. Suggest adding the sentence, "Providers delivering rehabilitative services to EPSDT eligible BI waiver participants must adhere to the BI waiver training requirements of 1 year experience or 40 hour training.	CMS does require EPSDT for children 21 and under. If the service provider for EPSDT does not have the expertise required, the service planning team needs to document that and work with the MCO to fill this gap.

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		95	All DME must be prescribed by a licensed physician or therapist. Limits access to DME.	Thank you for your comment. We will note your concern with KDHE.
		95	All communication devices must be recommended by a speech pathologist.	Thank you for your comment.
		136	"The MCO will request bids for vehicle modification services." Needs to be more explicit to indicate that the MCO is responsible for acquiring the bids and the task cannot be delegated to the consumer. Recommend they take out community resources (other states don't require this and though it was removed from home mods)	Thank you for your comment. We will clarify in the waiver that the MCOs are responsible for acquiring bids for vehicle modification services. Please refer to the Bulletin in the link below. https://kdads.ks.gov/kdads-commissions/long-term-services-supports
2	Goodlife Innovations		Thank you for all your work to provide for the Virtual Delivery of Services in our Kansas Waiver. The next generation of I/DD care will undoubtedly be service approaches that organically integrate remote and in-person human support (including automated support) in ways that best empower people to lead their preferred lives in small homes as independently, safely, and as privately as possible. To advance the vision of the final rule, I'm hopeful that we can propose a few important changes to the Kansas waiver language for how we use VDS. First, the current VDS waiver language appears to propose standards that do not equally apply to all methods of care. We should always use the approach to care that can produce the best outcome (the best and most preferred lifestyle) in the safest, least intrusive, and most private way possible. I'm hopeful that we can revise the VDS waiver language to ensure that all waiver care approaches (not just virtual or remote care) are measured against the same expectations (standards) for maximizing privacy, safety, and independence, while also achieving the lifestyle outcomes we want.	The PCSP needs to explain what services will be covered in-person versus virtual. The service code in the policy will be the same for both, but service delivery will be further clarified on the PCSP. Services are primarily billed one at a time with no overlap. Exceptions can be considered on a case-by-case basis to consider the participant's need for support while receiving Virtual Delivery of Services.

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			Second, the current VDS waiver language presents virtual support and in-home support essentially as opposing choice options. Some skills and needs are well met by a virtual coach, while other needs may require in-person care. Remote and in-home support are both needed, and often they are needed at the same time. A behavioral specialist can remotely support a DSP who is working alone to support a person with complex behavioral challenges. A nurse might remotely support a DSP who is concerned about an individual's health. A person served might prefer a manager or experienced remote coach to virtually be present to train/support a new staff person they don't know well. We must use support strategies that organically combine remote and in-home support if we hope to move away from traditional group home services and deliver care in smaller, more inclusive homes where one staff is supporting one or two persons with a range of needs. I'm hopeful we can revise language so that In-home and remote support can be used separately and in combination in ways that advance care, independence, and person-centered lifestyles. Please feel free to contact me if I might be of any assistance. We have drafted use policies for remote supports, and have drafted consents for how remote and in-home support, and would be happy to share them.	

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3	Stephanie L. Rasmussen <Stephanie.L.Rasmussen@sunflowerhealthplan.com>		**All Waivers – Personal Care Services**	
			a. Virtual Service Delivery- Recommend to add that the provider must be enrolled in KMAP and licensed to provide the service in the area of the state where the member resides- if this is true? How does the 200 mile rule apply for Home Health agencies?	PCS is not a licensed service. Home Health Agencies have licenses that prohibit the provision of service exceeding 200 miles. For other non-agency directed providers, this does not apply.
			b. Virtual Service Delivery- Recommend to add that both the MCO and the provider are responsible for documenting and tracking how the service is delivered. Also recommend to add that the provider must document the service that is delivered, in the same way as if it was in-person.	We will take this under review.
			c. Virtual Service Delivery- Recommend to add that the provider will respect the member's choice not to use virtual services at any given time; and will implement the back up plan for in-person support. This reinforces members can change their minds at any time and the back up option needs to be provided.	We will take this under review.