KDADS STANDARD POLICY

Policy Name:	Assistive Services: Home and Environmental Modification Services, Vehicle Modification Services, Specialized Medical Equipment and Supplies	**Policy Number:**	TBD
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Revision History			

Purpose

Kansas Medicaid is a jointly-funded state and Federal government program that pays for medically necessary services. Home and Community Based Service (HCBS) programs addresses the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are designed to enable people to stay in their homes, rather than moving to a facility for care. Home and Environmental Modification Services, Vehicle Modification Services and Specialized Medical Equipment and Supplies are important services for HCBS waiver recipients. This policy outlines principles and guidelines for accessing these waiver benefits.

Service:	Billing Code:
Home and Environmental Modification Services (HEMS)	S5165
Vehicle Modification Services (VMS)	T2039
Specialized Medical Equipment and Supplies (SMES)	T2029

Summary

Assistive Services is a term that refers to the type of service or technology aimed at improving the daily life and functional capabilities of people living with a disability. These services are defined in three separate services: Home and Environmental Modifications Services (HEMS), Specialized Medical Equipment and Supplies (SMES), and Vehicle Modification Services (VMS). Determining what services are needed how it will be assessed and implemented should always be done in partnership with the participant and their person-centered care planning team. Discussions regarding the services, their definition, and the process for accessing should be discussed at a minimum at the initiation of waiver services, when a change of condition triggers a new need, at the request of the participant, and at the Person-Centered Service Plan (PCSP) review.

Entities/Individuals Impacted

- Waiver participants
- Waiver participant's person-centered care plan team
- Managed Care Organizations

- Assistive Service Providers
- Transition Support Teams

I. Policy

A. Assistive Services are key services to support Kansans to return to the community from an institutional setting and/or remain successful in the community. Specifications for each waiver can be found in Appendix C of the HCBS waiver application. Participants should be evaluated at the stipulated timeframes noted in procedures or within 14 business days of notification of a potential need. Participants discharging from a facility should be evaluated at the time discharge planning is initiated and at minimum, 30 days prior to discharge. Modifications can be more time-intensive and adequate planning and referral time should be allowed. The Managed Care Organization (MCO) shall provide updates regarding the assistive service process to the participant at minimum every seven days.

1. Specialized Medical Equipment and Supplies (SMES)

    a) Specialized medical equipment and supplies include:

        i. Devices, controls, or appliances, specified in the PCSP, that enable participants to increase their ability to perform activities of daily living.

        ii. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

        iii. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant needs.

    b) SMES require prior authorization from the MCO via the participant's PCSP.

2. Vehicle Modification Services (VMS)

    a) Adaptations, alterations and/or specialized equipment to or for a vehicle that is the participant’s primary means of transportation. Consideration for backup equipment shall be made. Vehicle modifications are specified in the PCSP and are designed to accommodate the needs of the participant that enables the participant to integrate more fully into the community and to ensure the health, welfare and safety and integration by removing barriers to transportation.

    b) VMS requires prior authorization from the MCO via the participant's PCSP.

    c) Payment for VMS combined with HEMS and SMES shall not exceed $10,000 per participant, per waiver, per lifetime, except for I/DD waiver participants with no cap.

3. Home and Environmental Modification Services (HEMS)

a) Home and Environmental Modification Services (HEMS) are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence and to create a safer, healthier environment.

b) Home and Environmental Modifications include but are not limited to:

i. Physical and Environmental revisions such as grab bars, ramps, bathroom modifications, bedroom modifications, and any other modification to the home environment specified by the PCSP and that are designed to accommodate the needs of the participant to function with greater independence and to create a safer, healthier environment by removing barriers to their home.

c) HEMS Modifications require prior authorization from the MCO.

d) Payment for HEMS combined with VMS and SMES shall not exceed $10,000 per participant.

II. Procedures

A. Evaluation and Assessment

a. Due to the critical and urgent need of these services, timelines are specified below. Adherence to these timelines will ensure timely access and prevent prolonged hospital stays, safety concerns for participants and their support team and improve access to participants home and community-based services.
   i. Participants should be evaluated within 14 business days of notification of a potential need.
   ii. Participants discharging from a facility should be evaluated at the time discharge planning is initiated and at minimum, 30 days prior to discharge. Certain modifications can be more time intensive and therefore adequate planning and referral time should be considered to ensure a safe and effective transition planning process.
   iii. MCO shall obtain denials from primary insurance within five business days of request submission. MCO's shall make all efforts to ensure that denial from primary insurance for requested equipment is expedited. MCO's will update participants regarding status every seven days .
   iv. Providers contracted to provide Home Modification Services must provide a bid to the participant and MCO within 10 business days of the request and evaluation. If the 10 business days will not be meet the MCO will update the participant regarding the status of the bid.
   v. All steps to provide a decision to participants on assistive service requested should be determined within 30 days of the request. MCO's shall provide update to participants every seven days at a minimum.
b. Evaluation of Assistive Services shall be conducted upon initiation of discharge planning, initial service planning, bi-annual or annual service planning, or when there is a change in condition.
c. The MCO shall document the effectiveness of assistive services and increases independence within the PCSP.

B. Provider Requirements

a. Providers must follow the requirements outlined in Kansas HCBS Waivers including:
    i. Enrolled in KanCare
        1. Appropriately Licensed in Service that is being provided
        2. Certificate of Worker's Compensation and General Liability Insurance
        3. Proof of business establishment for a minimum of two (2) consecutive years
        4. Passing Background Checks consistent with the KDADS' Background Check policy
        5. Compliance with all regulations related to Abuse, Neglect, and Exploitation.
    ii. Non-KanCare enrolled-
        1. This entity will subcontract with a Center for Independent Living(CIL) perform the background checks.
        2. Affiliation with a (CIL)
        3. Certificate of Worker's Compensation and General Liability Insurance
        4. Proof of business establishment for a minimum of two (2) consecutive years
        5. Passing Background Checks consistent with the KDADS' Background Check policy
        6. Compliance with all regulations related to Abuse, Neglect, and Exploitation.

C. Assistive Services Procedures
    a. Assistive Services should be reviewed and discussed with the participant, the participant's support team, providers and the MCO and the potential service providers at these specified times:
    b. The MCO is required to document the effectiveness of assistive services and increase independence and accessibility to the community within the PCSP.
    c. SMES
        i. The participant's person-centered planning team shall partner with the participant to assess (SMES). This service is related to the PCSP to help the person achieve their outcomes.
        ii. The MCO will assess to ensure SMES is the appropriate avenue for purchase and will assist the participant in navigating various benefits to ensure timely submission and requests for these equipment needs.
        iii. The manual is on the KMAP DME website.
        iv. Durable Medical Equipment (DME) requires an order from a physician or other qualified practitioner and a visit is required.
        v. DME shall meet the definition in K.S.A. 65-1626.
        vi. DME shall meet the definition of medical necessity in K.A.R. 30-5-58.
        vii. Non DME or other assistive devices, controls or appliances require a documented assessment or statement by a qualified professional that assures the participant is receiving an appropriate item to meet their individual need.
        viii. Waiver funding requires prior authorization from the MCO via the participant's PCSP. Payment for Specialized Medical Equipment and Supplies (SMES) alone, or in combination with Home Modification Services, Vehicle Modification Services, may not exceed $10,000 per program participant per lifetime across waivers, with the exception of IDD.
        ix. When expenditure in excess of the $10,000 limit to maximize independence and functional abilities of the member in the home and community environment, the MCO shall furnish such needs using an 'in lieu of other services' approach, or using other value-added services provided by the MCO.
        x. The coverage/provision of SMES shall include the maintenance costs of devices, and training on the utilization of the devices furnished through this service.

xi. Ongoing training via rehabilitative services may be accessed via a waiver if an offered service or via the State Plan.

xii. A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO. In this case, the state shall provide a separate provider agreement that allows for the tribal vendor to receive direct payment from Medicaid.

d. VMS

i. The participant's person-centered planning team shall partner with the participant to assess VMS. This service is related to the PCSP to help the person achieve their outcomes. This should include back-up systems such as modified seating equipment when necessary.

ii. Payment for VMS alone, or in combination with HEMS, SMES, may not exceed $10,000 per program participant when necessary to maximize independence and functional abilities of the participant in the home and community environment. I/DD Waiver participants has no cap on this service.

iii. When exceeding the $10,000 limit would maximize independence and functional abilities of the participant in the home and community environment, the managed care organization shall furnish such needs using an 'in lieu of other services' approach, or using other value-added services provided by the MCO.

iv. Upon delivery to the participant (including installation), the Vehicle Modification must be in good operating condition in accordance with applicable specifications.

v. Assessment services will be provided to:

1. Help determine specific needs of the participant as a driver or passenger and review modification options to maximize participants access to and independence within the participant community.
2. An assessment of need is required for this service; a physician statement of need is not.

vi. VMS can be used for non-warranty covered vehicle modification repairs and training on use of the modification. Warranties at the time of modification Is allowed if determined to be of benefit.

vii. The following is specifically excluded from VMS:

1. Purchase or lease of new or used vehicles.
2. General vehicle maintenance or repair, except upkeep and maintenance of the modifications
3. State inspections, insurance, gasoline, fines or tickets and
4. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual.

e. HEMS

i. The participant's person-centered planning team shall partner with the participant to assess HEMS. This service is related to the PCSP to help the person achieve their outcomes and overcome barriers to health and safety.

ii. Waiver funding requires prior authorization from the MCO via the participant's PCSP.

iii. An assessment of need and scope of work is required for this service; a physician statement of need is not. This assessment should be completed with the participant and their support team.

1. The MCO may request an in-home or remote assessment of the participant's needs and recommendations from a therapist or a person qualified, to complete home

usability/accessibility assessment that includes the participant and legal representative, or other informal supports requested by the participant, for modifications.

iv. For consistent and maximal outcomes, the participant should be involved as much as possible in all scenarios with the provider and care team to ensure their input regarding their need is assessed for their home and community environment.

v. Based on participants reported needs and professional assessment of needs the MCO shall provide provisional approval of what modifications are approved.

vi. After MCO approval received, participants should be given a list of all approved home modification providers who can provide a bid for the needed and approved services assessed.
    1. The MCO shall work with the participant to provide any ongoing training and troubleshooting regarding the HEMS.

vii. The MCOs will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed.

viii. Bids that do not meet the participant's needs or submitted by contractors with a low work quality history will not be considered.

ix. Payment for HEMS alone, or in combination with, VMS and SMES, may not exceed $10,000 per program participant when necessary to maximize independence and functional abilities of the participant in the home and community environment.

x. I/DD Waiver participants has no cap on HEMS.

xi. When exceeding the $10,000 limit will maximize independence and functional abilities of the participant in the home and community environment, , MCO shall furnish such needs using an ‘in lieu of other services’ approach, or using other value-added services provided by the MCO

xii. Home modifications can be purchased in rented apartments or homes. The MCO will provide the landlord with education on how modifications could increase the property value. Best practices include:
    1. Maintain the modifications for a period of not less than three years
    2. Give first rent priority to tenants with physical disabilities.
    3. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
    4. Adaptations or an improvement to the home that is of general utility and is not of direct medical or remedial benefit to the participant is excluded.
    5. Home modifications may not add to the total square footage of the home except when necessary to complete the modification.

xiii. A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In the case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.

III. Documentation/Quality Assurance

A. Training and Quality Assurance:
    a. Providers must document the delivery and functionality of assistive services.
    b. MCO’s must provide oversight of provider training, qualifications and ongoing monitoring.
    c. Ongoing training may be accessed via waiver or State Plan as needed.

B. Quality assurance standards- Must be documented that the provider, participant and MCO can attest that the assistive service has been delivered and are functional for the participant. The MCO, participant and support team should have ongoing conversations if training is needed to maximize the use of the assistive services.

IV. Grievance Process

A. All standard grievance practices apply for assistive services. These can include:
   a. Contacting the KANCARE Ombudsman,
   b. Submitting a formal complaint either verbally or in writing to the MCO and contacting the KDADS Program Manager associated with the waiver under which the service is being requested.

V. Definitions

Person-Centered Service Plan - a written service plan developed jointly with an individual (and/or the individual's authorized representative) that reflects the services and supports that are important for the individual to meet the needs identified through a needs assessment, what is important to the individual regarding preferences for the delivery of such services and supports and the providers of the services and supports. (42 CFR § 441.725(a) and (b)).

Authority

Federal Authorities

42 CFR 441.301 Contents of request for a waiver

State Authorities

State of Kansas Home & Community-Based Services 1915(c) | Medicaid Waiver Programs

K.S.A. 65-1626.

K.A.R. 30-5-58

Related Information

PUBLIC COMMENT PERIOD: DD/MM/YY – DD/MM/YY

RELATED CONTENT:

Policy:

- Policy Name – location on the website

Manuals:

- Manual Name – Location online

ADDITIONAL LINKS:

Additional Links

Anything additional goes here.