APPENDIX K: Emergency Preparedness and Response

Background: This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. 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 completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: Kentucky

B. Waiver Title: Acquired Brain Injury/ Acquired Brain Injury Long Term Care/Supports for Community Living/Michelle P Waiver/Home and Community Based Waiver/Model II Waiver

C. Control Number:

KY0144.R06.01
KY0314.R04.01
KY0333.R04.01
KY0475.R02.01
KY0477.R02.01
KY40146.R06.01

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

☒	**Pandemic or Epidemic**
☐	**Natural Disaster**
☐	**National Security Emergency**
☐	**Environmental**
☐	**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.

1) On March 6, 2020, Governor Andy Beshear declared a state of emergency in Kentucky related to COVID-19 (also known publicly as "coronavirus'). The virus spreads quickly and can cause mild to severe symptoms. The spread of the virus poses a threat to health

and safety of our 1915(c) HCBS waiver participants and necessitates changes in service delivery methods and approaches.

2) As of February 12, 2021, Kentucky has had 300,366 confirmed cases, 1,063 currently hospitalized and 4,253 fatalities. The population served by the waivers includes individuals with acquired brain injuries, intellectual and developmental disabilities, the aged and physically disabled and individuals who are ventilator dependent. These populations are not only at a higher risk of contracting the virus, but are more likely to suffer complications up to, and including, death. At the same time, participants actively rely on waiver-funded support with activities of daily living, instrumental activities of daily living, supervision and oversight of care, and overall well-being. Many receive services in congregate settings, including adult day health cares. There are approximately 27,000 individuals currently enrolled in Kentucky's 1915(c) HCBS waivers.
3) The Department for Medicaid Services is working with our sister agencies, the Department for Behavioral Health and Intellectual Disabilities and the Department for Aging and Independent Living to provide direction and technical assistance to providers and participants. The Departments are following guidance provided by the Department of Public Health (DPH) and key federal agencies, including the Centers for Medicare and Medicaid and the Centers for Disease Control. Kentucky has created a website (kycovid19.ky.gov) that is being continually updated with information related to COVID-19. In addition, DPH is manning a 24-hour hotline for inquiries related to COVID-19 at 1-800-722-5725.
4) Kentucky seeks temporary changes to the HCBS waivers to continue to address staffing shortages, access to care issues and need for service provision beyond the terms of approved service descriptions to address participant health, safety and welfare for the duration of the emergency.
5) Kentucky is making the following additions to Appendix K effective January 1, 2022:
    a. K-2-d. modifies provider type qualifications for the following services: Case Management, Respite, Personal Assistance, Attendant Care, and Residential Services.
    b. K-2-d.-iii increases the number of individuals allowed in ABI and ABI LTC residential settings and adds Technology Assisted Residential to ABI and ABI LTC.
    c. K-2-f. temporarily increases payment rates for the following services: Attendant Care, Case Management (HCB and MPW only), Community Access, Community Guide, Community Living Supports, Community Transition, Companion, Home and Community Supports (HCB only), Homemaker, Non-Specialized Respite, Personal Assistance, Personal Care, Respite, Skilled Services by an LPN, Skilled Services by an RN, and Specialized Respite.
    d. K-2-j. allows for potential retainer payments for personal care, residential habilitation, adult day health care, and adult day training providers.

F. Proposed Effective Date: Start Date: 3/6/2020 **Anticipated End Date:** six months after the end of the federal PHE

G. Description of Transition Plan.

Individuals will transition back to pre-emergency service status once federal and/or state health officials have determined that the virus outbreak is adequately contained and

possesses minimal risks to revert to existing waiver practices. This transition will be implemented no sooner than 48 hours after the public has been made aware of pandemic containment and Medicaid providers have been notified of the intent to repeal emergency-based standards described herein. Providers will be given a period of 60 days to transition all participants' plans of care back to normal limits and operations within the approval time of the Appendix K

In keeping with existing practices, individualized needs will be re-assessed on a case-by-case basis, as indicated, if any long-term changes are required to an individual's person-centered service plan once the Commonwealth resumes standard program rules and policies approved in the active 1915(c) HCBS waiver applications.

H. Geographic Areas Affected:

Statewide

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

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. ☐ 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. ☐ Temporarily modify additional targeting criteria.
[Explanation of changes]

b. Services

i. ☒ Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ☒ 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]

The Department will permit a temporary increase beyond the currently defined waiver service caps and limitations including overtime to allow the needed amount, duration or change in scope within the waiver, as necessary, to effectively address emergent health, safety and welfare-related needs of program participants during the COVID-19 pandemic.

*Added 2021***:** *Approvals for overtime are limited to situations when a participant has more than one paid caregiver authorized on the plan of care and alternative caregivers or natural supports are not available due to the pandemic. Requests for increase in services not directly related to the pandemic will need to follow established limitations and exception processes if applicable.*

The following services will have limitations increased:

- Personal Care/Personal Assistance (ABI/ABI LTC/SCL/MPW)
- Companion (ABI/ABI LTC)
- Respite (All programs except MW II)
- Home Delivered Meals (All programs except MW II)
- PDS Services – (All programs except MW II)
- Specialized Medical Equipment and Goods and Services (All programs except MW II)
- Behavioral Support Services (MP II, ABI, ABI LTC)
- Consultative Clinical (SCL)
- Counseling (ABI, ABI LTC)
- Nursing supports (ABI LTC)
- Registered Nurse (MW II)
- Licensed Practical Nurse (MW II)
- Registered Respiratory Therapist (MW II)

Added 2021: Participants accessing residential services through a family home provider or adult foster care provider will be allowed to receive respite and personal assistance.

The Department will also allow for a temporary increase in Case Management services beyond one unit per month to address a participant's increased and emergent needs for information and referral, service linkage, crisis management and to promote timely access to services.

Added 2021: The Case Manager can also assist with participant's timely access to the COVID vaccine by reviewing information to determine eligibility, facilitate discussions with healthcare providers regarding any concern or potential contraindications, waitlist, access to transportation and vaccine appointments.

The case manager and the servicing provider will be responsible to review and substantiate a need and capacity to increase services to effectively address emergent health, safety and welfare-related needs of program participants during the COVID-19 pandemic. The Department does expect emergency modifications to a participant's person-centered plan to be both reasonable and necessary and will be performing retrospective reviews to assure that fraud, waste and program abuse does not occur as a result of this emergency response measure.

iii. ☐ 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. ☒ 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]:

Residential or Respite services can be provided in a Day Training or Adult Day Health Care centers according to federal guidance on safe practices related to mitigating COVID-19 spread. If space is sufficient to allow distancing and the center has the needed facilities (kitchen, bathrooms, sleeping arrangements and treatment rooms, including safe storage of medication).

The following services can be provided remotely using telephonic, video-conferencing, or web-based conferencing platforms that enable direct communication with the participant.

- Adult Day Training
- Adult Day Health
- Personal Assistance or Community Living Supports for reminders, cueing and/or monitoring of participant self-medication administration.

Services whose scope allows for the provision of telehealth services such as ancillary therapies, counseling and behavior services may provide and bill those covered waiver services using that delivery method.

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

i. ☒ Temporarily modify provider qualifications.

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

Added 2021: The PDS Coordinator role which supports CM and FMA activities in HCB waiver will be expanded to allow CMHCs to enroll and provide services to HCB participants who have a desire to access participant directed services in the waiver.

Required Training/Qualifications for non-skilled or non-licensed direct service providers including first aid, CPR and college of direct support required trainings, can be delayed to allow employees to begin immediately. Training required to support participants safely such as training on an individual's person centered plan, specific needs and medication administration when applicable are required.

The Department is amending provider standards for personal assistance, attendant care, home and community supports, respite, community living supports, and companion to qualify 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 (e.g. 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.

The Department will temporarily suspend all DAIL (Department of Aging and Independent Living) employee screening of immediate family members who will be temporarily authorized to provide PDS, if these services are required to cover gaps in care resulting from emergency-related inability to access waiver services. Pre-employment screenings (TB, background checks and drug testing will continue to be required with the exceptions noted above)

The Department will also temporarily waive requirements that out of state providers be licensed and located in Kentucky when they are actively licensed by another state Medicaid agency.

Added 2022: Case Management provider type qualifications will be modified to allow for Licensed Practical Nurses in all waivers and to modify the degree requirement from a Bachelor's degree to individuals who have an Associate's Degree or to allow for relevant experience to substitute for a degree in the provider qualifications. The age requirement for providers who provide respite, personal assistance, attendant care as well as residential staff will be decreased from twenty-one (21) to eighteen (18) when determined it is appropriate. This will allow for some of our health program vocational school students and college students to begin providing services and augment provider availability to provide additional services with the increase in staff.

ii. ☒ Temporarily modify provider types.

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

The Department will allow actively Medicaid-approved adult day health care providers to provide the following services:

- Home Delivered Meals
- In-Home Nursing Services (as long these services are furnished by a registered nurse and delivered in accordance with standards established by the Kentucky Board of Nursing)
- In-Home Respite
-

Additionally, standards are being relaxed to permit any enrolled waiver provider to provide Home Delivered Meals, as a precautionary measure that allows for service consolidation to limit an unnecessarily high volume of different providers and staff entering an individual's home environment, which limits potential opportunities for viral exposure.

Added 2021: Home delivered meals must follow the requirements listed in regulation and Section A of this appendix. Meals must be delivered to the participant's place of residence and do not include the purchase of bulk groceries.

If the only willing and able service provider in the participant's area is the case management provider, the Department or its designee will review the request for a conflict-free exemption utilizing the approved process in the approved waiver Appendix D-1. Services will be approved for 180 days or less and will require a new review at that time to assess the availability of additional providers.

iii. ☒ 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.]

Added 2022: The Department is increasing the number of participants permitted in a residential setting to up to five (5) in the ABI and ABI LTC waivers to ensure adequate capacity to serve individuals with emergency housing needs. The Department is also expanding Technology Assisted Residential service to the ABI and ABI LTC waiver, which will also allow up to five (5) participants in this setting. This modification must be executed

by providers in accordance with all participant rights requirements for provider-controlled residential settings as indicated in the HCBS Settings Rule of 2014. Case Managers and Residential Providers are required to complete and submit critical incident reports to the Department for any health, safety or welfare concern including COVID or infectious disease exposure or diagnosis. The Department monitors all incident reports and responds as warranted based on the level of the concern. Provider's safety and infection control policies are routinely reviewed during certification, recertification review and as needed during any investigations.

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

The Department will allow level of care evaluations or re-evaluations to be conducted remotely using telephonic, video-conferencing, or web-based conferencing platforms that enable direct communication between the individual completing the assessment and participant/participant's representative as permitted by HIPAA.

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].

To effectively respond to the COVID-19 outbreak, the state requires flexibility to adjust providers' rates in certain geographic areas to ensure that sufficient providers are available for participants. The state will determine the rates based on the severity of the situation in specific geographic region coupled with an individualized review of circumstances and extent of need and risk in light of unmet need that necessitates single-case agreement to increased rates to implement a sound and sustainable emergency person-centered service plan. Increased payment rates would follow the approved rate methodology in the waivers and allow up to an additional 50% of the max rate based on department approval.

Added 2022: The COVID-19 public health emergency and the nature of its extended duration have significantly reduced the availability of direct-care workers across all HCBS programs. To address the known workforce shortage, the Department will temporarily increase the rates of the services listed below by 50% of the most recently approved 1915(c) waiver reimbursement rate to accommodate known overtime demands and estimated wage inflation during the public health emergency.

Provider agencies receiving this increase will be required to ensure via a documented attestation to DMS that 85% of the increased reimbursement amount will be passed on to direct service workers (the workforce responsible to directly provide care to participants as specified in the service definition) in the form of compensation increases, hiring and retention bonuses and other reimbursement-related incentives to recover and maintain a sufficient workforce.

The service providers for the following agency-managed services are eligible for the increase through the end of this Appendix K approval:

- *Attendant Care*
- *Case Management – HCB and MPW only*
- *Community Access*
- *Community Guide*
- *Community Living Supports*
- *Community Transition*
- *Companion*
- *Home and Community Supports - HCB only*
- *Homemaker*
- *Non-Specialized Respite*
- *PDS Coordinator*
- *Personal Assistance*
- *Personal Care*
- *Respite*
- *Skilled Services by an LPN*
- *Skilled Services by an RN*
- *Specialized Respite*

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.]

The State will modify mandated processes and required timeframes for completing person-centered service plans as permitted by HIPAA:

1) Case managers may complete the person-centered service planning process using telephonic, video-conferencing, or web-based conferencing platforms that enable direct communication between the case manager and participant/participant's representative in accordance with HIPAA requirements.

2) Person-Centered Service Plans that are due to expire within the next 60 days require case management contact to the participant using allowable remote contact methods to verify with the participant or representative that the current PCSP assessment and service, including providers, remain acceptable and approvable for the upcoming year. The state will verify by obtaining electronic signatures from service providers and the individual or representative, in accordance with the state's HIPAA requirements.

If requested and/or necessary, modifications to a person-centered plan may be made, as driven by individualized participant need, circumstance and consent reviewed on an individualized basis, without the input of the entire person-centered service team.

The Department will temporarily allow changes to be modified primarily by the case manager and participant/participant's representative – with signature from the provider to deliver modified services as documented in the updated plan. Physical signature to the plan can be obtained from third parties using remote transmission methods. The

case manager may share forms requiring signature and receive documented signature consenting to a modified plan using fax or by sharing scanned documents via secured email. Consent may also be provided electronically via email. Electronic signature is also acceptable during the emergency period Planning and development of modified person-centered service plans may be conducted using remote contact methods, in keeping with all other allowances for case management activities during the emergency period.

3) The state will ensure the person-centered service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible to ensure that the specific service is delineated accordingly to the date it began to be received. The PCSP will be updated no later than 30 days from the date the service was initiated.

h. ☒ 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]

Providers must submit critical incident reports to report any waiver-funded disruption extending beyond three calendar days to services documented in the participant's person-centered service plan. This includes waiver-funded service disruptions that occur due to staff unavailability directly related to COVID-19 staff infection, quarantine or other pandemic-related circumstance.

Providers must submit critical incident reports for participants who tested positive for COVID-19, and disclose in the critical incident report the exposure of COVID-19 positive participants with any other 1915(c) HCBS waiver participants and/or staff. While reports will be required, providers do not need to conduct an investigation or submit a corrective action plan related to these reports, unless instructed directly to do so at the Department's discretion.

Provider must ensure that participants without natural or other supports continue to receive services.

i. ☒ 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.]

Added 2021: Allow waiver services to be provided to waiver participants in acute hospital settings when the hospital cannot meet the participant's immediate health, safety, and welfare needs. For example, an individual who is unable to communicate or does not have a communication device allowing him or her to express needs such as pain, hunger, toileting etc.

(A) identified in an individual's person-centered service plan (or comparable plan of care);

(B) provided to meet needs of the individual that are not met through the provision of hospital services;

(C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

(D) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities."

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.]

Added 2022: In response to the defined emergency, and in order to maintain a viable workforce, the state will make retainer payments to waiver providers of personal care and residential and day habilitation services, which include personal care. For calendar year 2021, The Department may provide up to three episodes of 30 consecutive days per beneficiary of retainer payments to both adult day health care and adult day training providers in addition to the initial retainer payments issued in 2020.

The state assures a retainer payment will not exceed the payment for the relevant service. The state will collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred or duplicate uses of available funding streams, as identified in a state or federal audit or any other authorized third-party review. The state will require an attestation from the provider that it will not lay off staff and will maintain wages at existing levels. The state will require an attestation from the provider that they had not received funding from any other sources, including but not limited to, unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE. If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

The Department will determine the rate and scope of retainer payments based on measurable declines in reimbursement as measured via a comparative claims analysis to compare a 90-day utilization period prior to the public health emergency to present utilization. Providers determined to have suffered or sustained a 50% or greater loss may be eligible for retainer payments. The amount of the payment will be based on census, claims data and eligibility based on the attestation mentioned above. Pursuant to Section 2: Medicaid Coverage of HCBS Retainer Payments during the COVID-19 PHE, State Medicaid Director Letter 21-003, retainer payments will not exceed three additional 30- day periods retroactive to 2021.

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]

The Department will temporarily suspend all required additional screening (potential financial conflict and pre-employment screenings) specifically required for immediate family members to approve them as an employee under PDS. It should be noted that this suspension is temporary – PDS employees, including immediate family members, will be required to undergo this screening once the emergency period has ended, however, a future determination of eligibility will not be applied to service rendered during the emergency period.

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]

Contact Person(s)

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

First Name:	Pam
Last Name	Smith
Title:	Division Director
Agency:	Department for Medicaid Services
Address 1:	275 E Main St
Address 2:	Mail Stop 6W-B
City	Frankfort
State	KY
Zip Code	40621

Telephone:	502-564-7540 ext 2105
E-mail	Pam.smith@ky.gov
Fax Number	502-564-0249

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

Signature: Lisa Lee

Date:	**02/16/2021**

State Medicaid Director or Designee

First Name:	Lisa
Last Name	Lee
Title:	Commissioner
Agency:	Department for Medicaid Services
Address 1:	275 E Main St
Address 2:	6W-A
City	Frankfort
State	KY

Zip Code	40621
Telephone:	502-564-4321
E-mail	Lisa.Lee@ky.gov
Fax Number	502-564-0509

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 which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are 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 Meal Service is defined as the provision of meals to a waiver participant who has a need for a home delivered meal based on a deficit in an activity of daily living or an instrumental activity of daily living identified during the assessment process. The service includes the preparation, packaging and delivery of safe and nutritious meals to a consumer at his or her home. A participant may be authorized to receive one home delivered meal per day. Also, for the purposes of this service, reheating a prepared home delivered meal is not the same as preparing a meal. Home delivered meals: 1) Shall be provided to participants who are unable to prepare their own meals and for whom there are no other persons available to do so. 2) Shall take into consideration the participant's medical restrictions 4) Shall be individually packaged if they are heated meals. 5) May include frozen meals 5) May be individually packaged if they are unheated, shelf-stable meals, or may have components separately packaged. *Added 2021: Meals must be delivered to the participant's place of residence and do not include the purchase of bulk groceries.*	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Up to 2 meals per day	

Provider Specifications				
Provider Category(s) *(check one or both)***:**				
	Certified Waiver Provider			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person		Relative/

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Certified Waiver Provider			•
			•

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method

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

[i] Numerous changes that the state may want to make 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; (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.