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State/Territory Name: KS

State Plan Amendment (SPA) #: 17-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

May 23, 2017

Susan Mosier, M.D.
Secretary and State Health Officer
Kansas Department of Health and Environment
Division of Health Care Finance
1000 SW Jackson Street, Room 540
Topeka, KS 66612

Dear Dr. Mosier:

On March 31, 2017, the Centers for Medicare & Medicaid Services (CMS) received Kansas' State Plan Amendment (SPA) transmittal #17-0003. This SPA was administrative in nature. The basic purpose was to account for all the current services being offered in the base benchmark plan.

SPA #17-0003 was approved on May 22, 2017, with an effective date of January 1, 2017, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Kansas State Plan.

If you have any questions regarding this amendment, please contact Karen Hatcher at (816) 426-5925.

Sincerely, 5/23/2017

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Sign

Enclosure

cc:
Mike Randol
Mary Ellen Wright
Bobbie Graff-Hendrixson

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:
Kansas
Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

17-0003

Proposed Effective Date

01/01/2017 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1937

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2017	$3881300.00
Second Year	2018	$3971050.00

Subject of Amendment

This amendment removes Donor Search - substitution and Biofeedback for urinary incontinence - substitution and added Temporomandibular Joint Disorder - substitution to the Additional Covered Benefits section of ABP5.

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**
  Describe:
- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:
Bobbie Graff-Hendrixson
Last Revision Date:
May 5, 2017
Submit Date:
Mar 30, 2017

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Working Healthy/WORK

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Ticket to Work Basic Group	Voluntary	X
+	Ticket to Work Medical Improvements Group	Voluntary	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

- ☐ Income Standard.
- ☐ Disease/Condition/Diagnosis/Disorder.
- ☒ Other.

Other Targeting Criteria (Describe):

Individuals whose functional limitations and need for assistance is similar to individuals meeting an institutional level of care.

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L __ OMB Expiration date: 10/31/2014

Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☐ Letter

☐ Email

☒ Other:

Describe:

The State has Benefits Specialists located regionally who meet individually with perspective Working Healthy/WORK enrollees to provide information about the program, provide a comparison to Home and Community Based waiver programs, and to explain that the program is voluntary and participants can dis-enroll at any time. (See attached Talking Points)

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Individuals are provided with program information, including the ability to voluntarily enroll or dis-enroll, following either a self-referral, or a referral by another entity.

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

When a participant chooses to dis-enoll, State program staff and MCO Case Managers assist them to transition to other Medicaid

services for which they are eligible.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other:

Describe:

The records will be maintained by the Kansas Department of Health and Environment (KDHE), the state agency that manages the WORK program. Records include demographic information, WORK Assessments, Individualized Budgets, Consumer Choice Forms, and Emergency Back-Up Plans in hard copy as well as in an Access Data Base.

What documentation will be maintained in the eligibility file? (Check all that apply.)

☐ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other:

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- (•) The state/territory is amending one existing benefit package for the population defined in Section 1.
- ( ) The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Work Opportunities Reward Kansans (WORK)

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- (•) Benchmark Benefit Package.
- ( ) Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ( ) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ( ) State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ( ) A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- (•) Secretary-Approved Coverage.
  - ( ) The state/territory offers benefits based on the approved state plan.
  - (•) The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Benefits include all those provided in the approved state plan plus additional benefits. The State assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP 5. The State assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.

Alternative Benefit Plan

- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Plan name: BC/BS of KS Comprehensive Maj. Medical-Blue Choice

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross Blue Shield of Kansas Comprehensive Major Medical-Blue Choice

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ Essential Health Benefit 1: Ambulatory patient services Collapse All ☐

Benefit Provided: Physicians' Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Hospital Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Licensed Practioners' Services
Source: State Plan 1905(a)
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization may be required for some services. Not a universal requirement.

Remove

Benefit Provided: Clinic Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice Care

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospice Notice of Election statement must be on file. In accordance with section 2302 of the ACA, individuals under the age of 21, will receive hospice care concurrently with curative care.

Benefit Provided: Certified Pediatric or Family Nurse Pract. Srvcs

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Personal Services - WORK/Self Direction

Source:

State Plan 1915(j)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See Other below

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

iv. Use of Cash

A. __X__ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

D. __X__ The State elects to provide self-directed personal assistance services to targeted populations.
Please describe:_____
Individuals whose functional limitations and need for assistance is similar to individuals meeting an institutional level of care.

E. __X__ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

1. During the initial and annual assessments, participants need for personal assistance is addressed in a person centered process. Particpants receive the number of hours that they are assessed as needing. Once needs are determined, hours of personal assistance are assigned. Hours of service are then translated into dollars, and a monthly allocation determined. Participants, with the help of Independent Living (IL) Counselors and anyone else they wish to include in the planning process, develop an Individualized Budget designed to address their needs. The Individualized Budget includes personal assistance, alternative assistance, and use of any carryover funds. Both the needs assessment and the Individualized Budget are reviewed by the Managed Care Organization (MCO) Case Manager to determine that the Individualized Budget addresses the needs of participants identified in the needs assessment.

2. In addition to addressing activities of daily living that pose a risk without assistance, the assessor and participant complete a Health Related Information assessment, which includes an assessment of home and neighborhood safety.

3. Participants, with the assistance of the assessor, and other significant persons if desired, develop an emergency back-up plan, document this plan on the Emergency Back-Up Plan form, and submit this to the Managed Care Organization (MCO) Case Manager for approval. The Emergency Back-up Plan is used to identify who will provide assistance in high-risk and emergency situations. MCO Case Managers review the Emergency Back-Up Plan to determine whether it includes the necessary safeguards, and either approves the plan, or returns it to the consumer and assessor with recommendations. Consumers, MCO Case Managers, Independent Living Counselors and State program staff maintain a copy of the Emergency Back-Up Plan and make it available as appropriate.

4. State program staff review the Needs Assessment, the Health Related form, the Emergency Back-Up Plan, the Consumer Agreement form and the Individualized Budget to assess whether they appear to meets the needs of the participant, that all information is complete, and that forms are signed by the participant or representative.

5. Assistive technology and home/vehicle modifications are available to participants who demonstrate a need for these for health and safety reasons. With the assistance of their IL Counselors, participants complete an Assistive Services Request Form, which is sent to their MCO Case Manager for approval.

6. Assessors, IL Counselors and MCO Case Managers are required to report any concerns regarding consumers living situations, emotional and physical abuse, neglect, exploitation and fiduciary abuse to KDHE and the Department of Children and Families (DCF). DCF is responsible for follow-up and investigation

B. The tools or instruments used to mitigate identified risks are described below.

1. The Needs Assessment tool is an assessment of functional limitations and is designed to identify support needs for Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADLs), and Employment Supports. The Needs Assessment tool requires a face-to-face meeting, and discussion with participants/representatives and anyone else they choose to include in the process, such as Independent Living Counselors (ILCs), other family members, and friends. The program is developed to provide needed support and yet encourage as much independence as possible.
The tool looks at the following for each ADL and IADL:
o Can the member perform these tasks independently?
o How much time does it require for the member to perform these tasks independently?
o Does the member need assistance but currently use unpaid natural support to perform the task?
o If natural support is currently used to accomplish these tasks, describe the nature of the natural support.
o Is assistive technology or home modifications currently used, or needed, to increase independence?
o If assistive technology is used or needed, describe the type of assistive technology or the home

modifications.
o Would personal assistance or assistive services reduce the amount of time?
o How much personal assistance is needed, or what assistive technology is needed, to increase safety and independence.

2. The Health Related Information within the Needs Assessment tool includes an assessment of:

o home and neighborhood safety
o safety equipment such as carbon monoxide and smoke detectors
o functionality of utilities
health and physical safety
o egress safety, and
o questions related to abuse, neglect and exploitation.

Participants may use their monthly allocation to purchase safety equipment such as smoke and carbon monoxide detectors. The intent to purchase safety items are documented on the participant's Individualized Budget.

3. The Emergency Back-up Plan provides the following information

o who should be contacted in the event a personal assistant does not come
o who to contact in the event of an emergency
o contacts who will provide assistance in an emergency/natural disaster
o contacts to care for service pet in the event of an emergency, and
o contact who is authorized to make decisions or sign documents.

4. The Individualized Budget documents

o who will be paid to provide personal assistance services
o what alternative services will be purchased, and
o how carry-over funds will be used to increase health, safety or independence.

5. The Assistive Services Request form

o describes the need for assistive technology or home/vehicle modifications, and
o documents the medical necessity for these services.

6. Background Check forms allow the Fiscal Management Service provider to perform background checks on personal assistants. Background checks will be paid by the participant's MCO and none of the cost of the background check will be deducted from the participant's Individualized Budget.

7. The Independent Living Counselor as a Mandated Reporter explains that Kansas law considers IL Counselors mandated reporters of abuse, neglect, exploitation, and fiduciary abuse, and defines these terms.

xiii. Qualifications of Providers of Personal Assistance

A. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xv. Permissible Purchases

A. ___X_ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

Remove

A. ___X__ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

ii. __X_ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. __X_ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

Benefit Provided:

Supported Employment - Ind Emp Sup Ser

Source:

State Plan 1915(i)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services are limited to individual program criteria and are based on a person centered planning process.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Individuals must have a medical and functional need for the Supported Employment - Individual Employment Support services in order to improve health and safety and/or increase the ability to maintain employment. Supported Employment - Individual Employment Support Services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce. Supported employment services are individualized and may include support to learn new or evolving and changing job responsibilities, to exhibit appropriate work behavior, to interact appropriately with other employees and the general public, to practice safety measures at work, and transportation to and from work. It may also include job coaching and consultation with the employer to deal with employment related issues and/or job related adaptations or modifications. Supported Employment - Individual Employment Supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business. For those who are self-employed, Supported Employment – Individual Support Medicaid is not provided to defray the expenses associated with starting up or operating a business. Providers of Supported Employment - Individual Support are community service providers, selected by the individual, who have trained staff such as job specialists, job developers, supported employment specialists,

etc. Individuals who are self-directing may use community service providers or establish their own provider qualifications for the provision of individual employment supports.

For any Home and Community Based Services benefits as permitted in 1915(i) in ABP5, the state assures that:
1. The service(s) are provided in settings that meet HCB setting requirements;
2. The service(s) meet the person-centered service planning requirements;
3. Individuals receiving these services meet the state-established needs-based criteria that are not related solely to age, disability, or diagnosis, and are less stringent than criteria for entry into institutions. Services can be accessed as needed, even if the individuals have needs that are below institutional level of care.

Remove

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services — Collapse All

Benefit Provided: Emergency Hospital Services - Outpatient Hospital
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transportation - Outpatient Hospital
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided: Inpatient Hospital Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Physicians' Services - Inpatient
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice Services - Inpatient
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For symptoms management of the hospice diagnosis. In accordance with section 2302 of the ACA, individuals under the age of 21, will receive hospice care concurrently with curative care.

Remove

Add

Alternative Benefit Plan

☑ Essential Health Benefit 4: Maternity and newborn care Collapse All ☐

Benefit Provided: Nurse-Midwife Services
Source: State Plan 1905(a) Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Ambulatory Prenatal Care-Physicians
Source: State Plan 1905(a) Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inpatient Hospital - Maternity
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Add

Alternative Benefit Plan

Collapse All ☐

☑ Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided: Community Psychiatric Support and Treatment-Rehab.

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Mental Health In-patient Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Individuals assessed to be admitted for inpatient acute care related to psychiatric services in which the psychiatric plan of care is directed by a psychiatrist and in which psychotherapy is provided on a daily basis. These services are not provided in an IMD.

Benefit Provided: Substance Abuse Out-patient Services-Rehab

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient Substance Abuse Services includes an array of consumer centered outpatient and intensive outpatient services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors.

Benefit Provided:
Substance Abuse In-patient Hospital Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Acute medical detoxification hospital level of care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
These services are not provided in an IMD. Residential treatment also covered.

Benefit Provided:
Psychosocial Rehabilitation-Rehabilitation

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Kansas ABP prescription drug benefit is the same as under the approved Medicaid state plan for prescribed drugs. KS Medicaid covers all federally rebated drugs.

Alternative Benefit Plan

■ Essential Health Benefit 7: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided: Physical Therapy and Related Services: PT

Source: State Plan 1905(a) Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Adult 6 mos per illness or injury/children none

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided in accordance with CFR 440.110. Used to define both rehabilitative and habilitative services. Six month limit for adults can be extended with medical necessity documentation.

Benefit Provided: Physical Therapy and Related Services: OT

Source: State Plan 1905(a) Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Adult 6 mos per illness or injury/children none.

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided in accordance with CFR 440.110. Used to define both rehabilitative and habilitative services. Six month limit for adults can be extended with medical necessity documentation.

Benefit Provided: Physical Therapy and Related Services: ST

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Adult 6 mos per illness or injury/children none

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided in accordance with CFR 440.110. Used to define both rehabilitative and habilitative services. Includes audiological testing and evaluation by an audiologist. Six month limit for adults can be extended with medical necessity documentation.

Remove

Benefit Provided:

Home Health Services: Medical supplies, equipment

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Home Health Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services — Collapse All

Benefit Provided: Other Laboratory and X-Ray Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All ☒

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	
		Remove

Add

Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
PA may be required for services in excess of adult benefit limitations. Medical necessity documentation may be required.

Add

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted:
Prim. Care Visit to Treat Injury or Illness - dup

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary Care Visit to Treat an Injury or Illness is mapped to EHB 1, Physicians' Services and 1905(a). The services are a duplication of physicians' services under the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Specialist Visit - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialist Visit is mapped to EHB 1, Other Licensed Practitioners' Services and 1905(a). The services are a duplication of other practitioners' services under the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Other Practitioner Office Visit - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Other Practitioner Office Visit is mapped to EHB 1, Other Licensed Practitioners' Services and 1905(a). The services are a duplication of other practitioners' services under the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Out Pt Fac. Fee(e.g., Amb. Surg. Ctr.) - duplica

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient Facility Fee(e.g., Amb. Surgery Ctr.) is mapped to EHB 1, Outpatient Hospital Services and Clinic Services and 1905(a). The services are a duplication of outpatient hospital and clinic services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Out Pt Surg. Phys./Surg. Svs. - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient Surgery Physician/Surgical Services are mapped to EHB 1, Outpatient Hospital Services and Clinic Services and 1905(a). The services are a duplication of outpatient hospital and clinic services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Out Pt Fac. Fee/Abortion - duplication

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Out Pt Fac. Fee/Abortion is mapped to EHB 1, Outpatient Hospital Services and Clinic Services and 1905(a). The services are a duplication of outpatient hospital and clinic services from the approved Medicaid State Plan.

Remove

Base Benchmark Benefit that was Substituted:

Out Pt. Surg. Phys./Surg. Ser./Abortion - duplicat

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Out Pt. Surg. Phys./Surg. Ser. (Abortion) is mapped to EHB 1, Outpatient Hospital Services and Clinic Services and 1905(a). The services are a duplication of outpatient hospital and clinic services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Urgt. Care Out Pt. Ctrs or Fac. - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Urgent Care Out Pt. Centers or Facilities are mapped to EHB 1, Outpatient Hospital Services and Clinic Services and 1905(a). The services are a duplication of outpatient hospital and clinic services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Hospice Care - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice Care is mapped to EHB 1, Hospice Care and 1905(a), and EHB 3, Hospice Services-Inpatient and 1905(a). The services are a duplication of hospice care services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Routine Foot Care - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine Foot Care is mapped to EHB 1, Other Licensed Practitioners' Services and 1905(a). The services are a duplication of other practitioners' services under the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Home Health Care Services - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home Health Care Services is mapped to EHB 7, Home Health Services and 1905(a). The services are a duplication of home health services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Emergency Room Services - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Emergency Room Services are mapped to EHB 2, Emergency Hospital Services and 1905(a). The services are a duplication of outpatient hospital services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Emrgncy Trans./Ambulance - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Emergency Transportation/Ambulance is mapped to EHB 2, Emergency Transportation and 1905(a). The services are a duplication of outpatient hospital services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
In Pt. Hosp. Svc (e.g., Hospital Stay) - duplicati
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
In Pt. Hospital Services (e.g., Hospital Stay) is mapped to EHB 3, Inpatient Hospital services and 1905(a). The services are a duplication of inpatient hospital services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
In Pt. Phys. and Surg. Srvcs - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
In Pt. Physician and Surg. Services is mapped to EHB 3, Physicians' Services-Inpatient and 1905(a). The services are a duplication of inpatient hospital services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
In Pt. Hosp. Svcs (e.g. Hosp. Sty) Abortion - dupl
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
In Pt. Hosp. Services (e.g., Hosp. Stay) Abortion is mapped to EHB 3, Inpatient Hospital Services and 1905(a). The services are a duplication of inpatient hospital services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
In Pt. Phys. and Surg. Srvcs (Abortion) - duplicat
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
In Pt. Physician and Surg. Services (Abortion) is mapped to EHB 3, Physicians' Services-Inpatient and

1905(a). The services are a duplication of inpatient hospital services from the approved Medicaid State Plan.

Remove

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prenatal and Postnatal Care is mapped to EHB 4, Ambulatory Prenatal Care-Physicians and 1905(a). The services are a duplication of physicians' services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Dlvry & all In Pt. Srvcs for Mat. Care - duplicati

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & all In Pt. Services for Maternity Care is mapped to EHB 4, Inpatient Hospital-Maternity and 1905(a). The services are a duplication of physicians' services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Ment/Behav Hlth Out Pt. Srvcs - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/Behavioral Health Out Pt. Services is mapped to EHB 5, Community Psychiatric Support and Treatment-Rehabilitation, Psychosocial Rehabilitation-Rehabilitation, and 1905(a). The services are a duplication of Community Psychiatric Support and Treatment services and Psychosocial Rehabilitation from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Ment/Behav Hlth In Pt. Services - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/Behavioral Health In Pt. Services is mapped to EHB 5, Mental Health In-patient Services and 1905(a). The services are a duplication of inpatient acute care related to psychiatric services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Substance Abuse Dis. Out Pt. Srvcs - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance Abuse Disorder Out Pt. Services is mapped to EHB 5, Substance Abuse Out-patient Services-Rehab and 1905(a). The services are a duplication of outpatient Substance Abuse Services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Substance Abuse Dis. In Pt. Srvcs - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance Abuse Disorder In Pt. Services is mapped to EHB 5, Substance Abuse In-patient Hospital Services and 1905(a). The services are a duplication of acute medical detoxification hospital services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Prescription Drugs - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prescription Drugs are mapped to EHB 6, Prescription Drugs and 1905(a). The services are a duplication of prescription drugs services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Out Pt. Rehabilitation Services - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Out Pt. Rehabilitation Services is mapped to EHB 7, Physical Therapy and Related Services and 1905(a). The services are a duplication of PT, OT, ST under 440.110 and covered by the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Durable Medical Equipment - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable Medical Equipment is mapped to EHB 7, Home Health Services: Medical supplies, equipment and 1905(a). The services are a duplication of home health services covered by the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Diagnostic Test (X-ray and Lab work) - duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diagnostic Test (X-ray and Lab work) services are mapped to EHB 8, Other Laboratory and X-Ray Services and 1905(a). The services are a duplication of other laboratory and x-ray services covered by the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:
Routine Eye Exam (Pediatric) - duplication
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine Eye Exam is mapped to EHB 10, EPSDT and 1905(a). The services are a duplication of the optometrists' services covered by the approved Medicaid State Plan.

Remove

Base Benchmark Benefit that was Substituted:

Preventive Care/Screening/Immunization - duplicati

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive Care/Screening/Immunization is mapped to EHB 9, Preventive and wellness services and chronic disease management and 1905(a). The services are a duplication of preventive and wellness services and chronic disease management under the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Infertility Treatment - substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Personal Services-WORK/Self Direction and Supported Employment - individual employment support services in EHB1 is substituted for Infertility Treatment. Actuaries have determined the cost of Personal Services-WORK/Self Direction exceeds the cost of Infertility Treatment.

Base Benchmark Benefit that was Substituted:

Temporomandibular Joint Disorder - substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Personal Services-WORK/Self Direction and Supported Employment - individual employment support services in EHB1 is substituted for Temporomandibular Joint Disorder Treatment. Actuaries have determined the cost of Personal Services-WORK/Self Direction exceeds the cost of Temporomandibular Joint Disorder Treatment.

Base Benchmark Benefit that was Substituted:

Diabetes Education - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diabetes Education is mapped to EHB 9, Preventive and wellness services and chronic disease management and 1905(a). The services are a duplication of preventive and wellness services and chronic disease management under the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Certified Pediatric or Family Nurse Practioner-dup

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Certified Pediatric or Family Nurse Practioner is mapped to EHB 1, Certified Pediatric or Family Nurse

Pract. Srvcs and 1905(a). The services are a duplication of pediatric services under the approved Medicaid State Plan.

Remove

Base Benchmark Benefit that was Substituted:

Physician Services - Inpatient - duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Physician Services-Inpatient is mapped to EHB 3, Physicians' Services-Inpatient and 1905(a). The services are a duplication of inpatient physician services from the approved Medicaid State Plan.

Base Benchmark Benefit that was Substituted:

Delivery/Inpat. Ser. for Maternity Care - dup

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery and All Inpatient Services for Maternity Care is mapped to EHB 4, Nurse-Midwife Services and 1905(a). The services are a duplication of nurse-midwife services in the approved Medicaid State Plan.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-Emergency Care When Traveling Outside US

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Kansas Medicaid does not cover any services outside of the United States.

Add

Alternative Benefit Plan

☐ Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Alternative Benefit Plan

☒ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

Benefit Provided: Nursing Facility Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services as specified in the Medicaid State Plan.

Other: Provided to beneficiaries assessed for the level of need for nursing facility. This can be either rehabilitation or long term care.

Benefit Provided: Peer Support-Rehabilitation

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services as specified in the Medicaid State Plan.

Other: Activities included must be intended to achieve the identified goals or objectives as set forth in the consumer's individualized treatment plan.

Benefit Provided: Crisis Intervention-Rehabilitation

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services as specified in the Medicaid State Plan.

Other:

No PA is required for crisis services. The language in the “Limitations/Exclusions is as follows “Re-evaluation for the need of crisis services is to be completed by a QMHP every 72 hours or more frequently as needed.”

Remove

Benefit Provided: Extended Services for Pregnant Women

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: 60 days postpartum coverage

Scope Limit:

Services as specified in the Medicaid State Plan. Pregnancy related and postpartum services for a 60 day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Other:

Services for any other medical conditions that may complicate pregnancy.

Benefit Provided: Routine Eye Exam (Adult)

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: One exam per year

Duration Limit: None

Scope Limit:

Services as specified in the Medicaid State Plan.

Other:

Benefit Provided: Dental Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Services must be medically necessary and are limited to those specified in the Medicaid State Plan.

Other:

In addition, the MCOs offer prophylactic cleanings at least once per year.

Remove

Benefit Provided:

Eyeglasses

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Yes, see Other below.

Duration Limit:

None

Scope Limit:

Yes, see Other below.

Other:

One pair (lenses and frames) for adults every 48 months.

Benefit Provided:

Assistive Services - WORK

Source:

State Plan 1915(i)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Other

Duration Limit:

None

Scope Limit:

Services are limited to individual program criteria and are based on a person centered planning process.

Other:

Individuals must have a medical and functional need for the assistive technology or services in order to improve health and safety and/or increase the ability to maintain employment. Assistive Services includes items, equipment, product systems, and home or vehicle modifications, not covered under the Medicaid State Plan, but which contribute to the individual's health and safety and/or ability to maintain employment and independence. Assistive Services may also include services which directly assist individuals with a disability in the selection, acquisition, or use of assistive technology. The Assistive Service requested must be prior authorized and must be related to the individual's disability and functional limitations, medically necessary and documented by appropriate medical personnel, and cannot go beyond the scope of the Medicaid program and subsume an employer's responsibilities under Title I of the Americans with Disabilities Act (ADA), and the Kansas Act Against Discrimination.

For any Home and Community Based Services benefits as permitted in 1915(i) in ABP5, the state assures that:
1. The service(s) are provided in settings that meet HCB setting requirements;
2. The service(s) meet the person-centered service planning requirements;
3. Individuals receiving these services meet the state-established needs-based criteria that are not related solely to age, disability, or diagnosis, and are less stringent than criteria for entry into institutions. Services

can be accessed as needed, even if the individuals have needs that are below institutional level of care.

Any services that exceed $7,500 annually require prior authorization based on Medical Necessity.

Provider Qualifications: Community organizations eligible to enroll as providers of Assistive Services must be providers of DME, orthotics and prosthetics or be one of the following: CDDO or CDDO Affiliate, CIL, or licensed Home Health Agency.

Remove

Benefit Provided:

Independent Living Counseling - WORK

Source:

State Plan 1915(j)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

40 units (quarter hour) per month.

Duration Limit:

None

Scope Limit:

Services are limited to individual program criteria and are based on a person centered planning process.

Other:

Independent Living Counseling is provided for WORK participants by Independent Living Counselors working for community organizations such as Centers for Independent Living, Community Developmental Disability Organizations, and licensed Home Health agencies. Independent Living Counselor responsibilities include conveying WORK program policies and procedures to participant and assisting participants to:

- complete the WORK Choice Form
- access training and supports needed to develop the skills to self-direct services, manage their monthly allocation, organize workplace accommodations, and otherwise meet goals for independent living
- develop an Individualized Budget
- determine and locate alternate, cost-effective methods for purchasing services
- plan for the use of carry-over funds
- develop an Emergency Back-Up Plan and locate emergency back-up care and emergency assistance
- recruit providers of personal assistance services
- interview, hire, supervise, and terminate personal assistants
- obtain agency-directed services, if that is their preference
- document the need for and apply for assistive services, as well as locate providers
- complete and submit required paperwork for the fiscal intermediary
- dis-enroll from the program.

Independent Living Counselors are also responsible for communicating any changes in status, needs, problems, etc., to the participant's MCO Case Manager, report emotional abuse, physical abuse, exploitation, fiduciary abuse, maltreatment and/or neglect to the program staff and/or Adult Protective Services.

Extra units may be added based on medical necessity.

For any Home and Community Based Services benefits as permitted in 1915(i) in ABP5, the state assures that:

1. The service(s) are provided in settings that meet HCB setting requirements;
2. The service(s) meet the person-centered service planning requirements;
3. Individuals receiving these services meet the state-established needs-based criteria that are not related solely to age, disability, or diagnosis, and are less stringent than criteria for entry into institutions. Services can be accessed as needed, even if the individuals have needs that are below institutional level of care.

Provider Qualifications:
1. Be employed by a Center for Independent Living, Community Developmental Disability Organization or its affiliate, or a licensed Home Health Agency that is enrolled as a provider of independent living counseling services;
2. Have a minimum of one year of professional experience providing direct services, including case management;
3. Have a minimum of 6-months experience working with a person with a disability as recognized by the Rehabilitation Act of 1973;
4. Have attended a 2-hour WORK presentation;
5. Have at least 12 hours of standardized training annually; and
6. Have completed the on-line WORK Independent Living Counseling training and received the certificate of completion.

Remove

Add

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

The majority of children ages 0 - 21 will continue to receive EPSDT through the KS Medicaid State Plan. A very small number of children ages 16 to 21 may be employed and eligible for the KS Medicaid Buy-In program, Working Healthy, in which case they may receive all EPSDT services as well as the services available through the Alternative Benefit Plan.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

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- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☐ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State received approval to implement "KanCare", managed care for the majority of its Medicaid enrollees, including individuals enrolled in the Benchmark Benefit Plan WORK. KanCare was authorized by CMS under the 1115 authority, and began January 2013. Prior to submitting the 1115 waiver application, the Administration sought public input through an open process that included a Request for Information in February 2011, and an open-door policy with stakeholders and advocates. In the summer of 2011, the State of Kansas facilitated a Medicaid public input and stakeholder consultation process, during which more than 1,700 participants engaged in discussions on how to reform the Kansas Medicaid system. Participants produced more than 2,000 comments and recommendations for reform. After three public forums in Topeka, Wichita and Dodge City, web teleconferences were held with stakeholders representing Medicaid population groups and providers. The State also made an online comment tool available, and a fourth, wrap-up public forum was conducted in Overland Park in August 2011. The State carefully considered the input from this process and from meetings with advocates and provider associations. In November 2011, Kansas announced a comprehensive Medicaid reform plan that incorporated the themes that had emerged from the public process, including integrated, whole-person care; preserving and creating paths to independence; alternative access models; and enhancing community-based services. The State released a Request for Proposals (RFP) on November 8, 2011, and submitted to CMS a Section 1115 Demonstration Project proposal in the form of a concept paper on January 26, 2012. Advance notice of the Demonstration Project was distributed to tribal representatives, and an initial tribal consultation meeting with representatives of each tribal government was conducted on February 22, 2012. Statewide educational tours where stakeholders provided additional input were conducted from August 2012 through February 2013. In addition, weekly "Rapid Response" calls were held with consumers, providers and other stakeholders from January through June 2013 in order to address to address concerns as quickly as possible.

MCO: Managed Care Organization

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The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: January 1, 2013

Describe program below:

KanCare is delivering whole-person, integrated care to more than 360,000 consumers across the state. Kansas has contracts with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administers KanCare within the State of Kansas. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the Medicaid waiver programs for disability services, mental health and substance abuse, as well as operates the state hospitals and institutions. Each Medicaid consumer has a choice at application for benefits regarding from which MCO they want to receive services. If they do not choose at application, they will be randomly assigned to an MCO. Consumers in KanCare receive all the same services provided under the previous Medicaid delivery system, plus additional services. However the inclusion of services provided through the Home and Community Based Services waiver for consumers with intellectual or developmental disabilities (I/DD) was delayed for one year and became part of KanCare on January 1, 2014. In addition to the services that were available to Medicaid consumer prior to 2013, the three health plans offer value added services to their members, e.g., such as basic preventive dental care for adults. Consumers have the option during open enrollment season once a year to change to a different KanCare health plan if they prefer to do so. The open season corresponds with their anniversary month of enrollment in the program. All pre-2013 Medicaid services are provided through the KanCare health plans. These include physical health services such as doctor appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care. All the services offered through the State's Home and Community Based Services waivers are part of KanCare (with the exception of the previously noted waiver services for people with I/DD, which became part of KanCare February 1, 2014). The KS Medicaid Buy-In program, Working Healthy, and the supplemental Benchmark Benefit WORK, are also in KanCare. KanCare health plans are required to coordinate all of the different types of care a consumer receives. The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The health plans focus on ensuring that consumers receive the preventive services and screenings they need and ongoing help with managing chronic conditions.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Employer Sponsored Insurance and Payment of Premiums	ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The state assures that employer sponsored insurance (ESI) coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package in the alternative benefits plan known as the KS Working Healthy/Work plan. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **No**

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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Payment Methodology	**ABP11**

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

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