Table of Contents

State/Territory Name: Kansas

State Plan Amendment (SPA) #: 23-0026

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 14, 2023

Christine Osterlund, Acting State Medicaid Director
Kansas Department of Health and Environment
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

Re: Kansas State Plan Amendment (SPA) 23-0026

Dear Acting Director Osterlund:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0026. This amendment proposes to add the Alternative Benefit Plan (ABP) for the Supports and Training for Employing People Successfully (STEPS) program.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act. This letter is to inform you that Kansas Medicaid SPA 23-0026 was approved on December 14, 2023, with an effective date of January 1, 2024.

If you have any questions, please contact Helenita Augustus at 410-786-8902 or via email at Helenita.Augustus@cms.hhs.gov.

Sincerely,

[redacted]

Digitally signed by Ruth Hughes -S
Date: 2023.12.14 09:23:05 -06'00'

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

cc: Bobbie Graff-Hendrixson
Bill Stelzner
Bill Thompson
Annette Grant

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Kansas**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

KS-23-0026

Proposed Effective Date

01/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 440 Subpart C

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	24	$ 0.00
Second Year	25	$ 0.00

Subject of Amendment

Adding the STEPS program to the Alternative Benefit Plan

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:	**Dec 8, 2023**
Submit Date:	**Oct 10, 2023**

Alternative Benefit Plan

State Name: Kansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name: STEPS

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:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	SSI Beneficiaries	Voluntary	Remove
Add	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	Remove
Add	Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	Voluntary	Remove
Add	Disabled Adult Children	Voluntary	Remove
Add	Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	Voluntary	Remove
Add	Work Incentives Eligibility Group	Voluntary	Remove

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):

Medicaid beneficiaries in the specified eligibility groups ages 16 through 64 who meet any of the following criteria:
i. Have specified behavioral health primary diagnoses and need support to live and work in the community.
ii. Are on the Intellectual/Developmental Disability (I/DD), Physical Disability (PD), or Brain Injury (BI) HCBS 1915(c) waiver waiting list.
iii. Are on the I/DD, PD, or BI HCBS 1915(c) waivers, willing to leave their waiver, and want to participate in STEPS.

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.20181119

Alternative Benefit Plan

State Name: Kansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

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 Working Healthy Benefits Specialists located regionally who meet individually with prospective STEPS participants to provide information about the program. 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 disenroll, 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 disenroll, State program staff and MCO care coordinators assist them to transition to other Medicaid services for which they are eligible.

Alternative Benefit Plan

☑ 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 STEPS program. Records include each participant's demographic information, STEPS assessments, individualized STEPS Service Plan, Participant Agreement, and Emergency Back-Up Plan in hard copy as well as electronically.

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

V.20160722

Alternative Benefit Plan

State Name: Kansas Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: KS - 23 - 0026

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3.1

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: STEPS

Selection of EHB-Benchmark Plan

The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: BC/BS of KS Comprehensive Maj. Medical-Blue

The EHB-benchmark plan is the same as the Section 1937 Coverage option: No

Indicate the EHB-benchmark option as described at 45 CFR 156.111(b)(2)(B) the state/territory will use as its EHB-benchmark plan:

State/Territory is selecting one of the below options to design an EHB package that complies with the requirements for the individual insurance market under 45 CFR 156.100 through 156.125.

- ◉ State/Territory is selecting the EHB-benchmark plan used by the state/territory for the 2017 plan year.
- ○ State/Territory is selecting one of the EHB-benchmark plans used for the 2017 plan year by another state/territory.
- ○ State/ Territory selects the following EHB-benchmark plan used for the 2017 plan year but will replace coverage of one or more of the categories of EHB with coverage of the same category from the 2017 EHB-benchmark plan of one or more other states
- ○ Select a set of benefits consistent with the 10 EHB categories to become the new EHB-benchmark plan. (Complete and submit the ABP5: Benefits Description form to describe the set of benefits.)

Type of EHB-benchmark plan:

- ◉ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ 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.

Alternative Benefit Plan

Assurances

☑ The state/territory assures the EHB plan meets the scope of benefits standards at 45 CFR 156.111(b), does not exceed generosity of most generous among a set of comparison plans, provides appropriate balance of coverage among 10 EHB categories, and the scope of benefits is equal to, or greater than, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2).

☑ The state/territory assures that all services in the EHB-benchmark plan have been accounted for throughout the benefit chart found in ABP 5.

☑ The state/territory 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 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 of those provided in the approved state plan plus additional STEPS benefits. The State assures that all services in the base benchmark have been accounted for through the benefit chart found in ABP5. 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.

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

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.20190813

Alternative Benefit Plan

State Name: Kansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (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.20160722

Alternative Benefit Plan

State Name: Kansas

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: KS - 23 - 0026

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

☑ 1. Essential Health Benefit: 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 Practitioners 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:

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

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)

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:

Personal Assistance Services - STEPS

Source:

State Plan 1915(i)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

24 hours per day

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:

Personal Assistance Services (PAS) are designed to provide hands-on assistance, or cuing and prompting, for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). PAS can be provided as a self-directed (employer authority, not budget authority) and/or agency-directed service. PAS includes methods of obtaining assistance, including: Enhanced Services (assistance for participants who require hands-on care during the night, including re-positioning, tracheotomy care, and care for chronic incontinence; need must be documented by a physician); cooking meals and cleaning, and reminders or queuing activities.

The need for PAS is determined through the STEPS assessment and person-centered planning process and documented in the participant's individualized STEPS Service Plan. The need for PAS is evaluated with the need for other services that could reduce the need for hands-on assistance such as home delivered meals or other benefits.

Only participants who meet criteria determined through assessment and the person centered planning process are eligible to receive these services. Participants must have a physical or intellectual/developmental disability and need physical assistance with ADLs or IADLs. Participants must demonstrate needing support for at least two ADLs per the assessment process. PAS is only provided in settings that comply with the home and community based services (HCBS) settings requirements.

Personal Assistance Services cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation. PAS that can be covered under the state plan should be furnished to participants under the age of 21 as services required under EPSDT.

Provider Qualifications: Personal assistants (PAs), whether self or agency-directed must be 18 years of age or older to provide paid support for ADLs. PAs who are 14-18 years of age may provide paid support for IADLs at specified levels. PAs, whether self- or agency-directed, are required to pass State and National criminal history background checks.

PAS can only be provided by a Legally Responsible Individuals (LRI) when such services are deemed extraordinary, which means care exceeding the range of activities that an LRI would ordinarily perform in

the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. A court appointed legal guardian, conservator, or a durable power of attorney are not permitted to be a paid provider for the participant unless the probate court determines that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068 and STEPS policy.

Under extenuating circumstances, legally responsible individuals are able to provide this service. The exceptions process is as follows:
STEPS is not required to make exceptions to any policy. Exceptions are at the discretion of the MCO or KDHE. Exceptions must be approved before implementation with documentation in the service plan and must follow normal provider enrollment and payment procedures.

1. The LRI is one of the following: guardian, conservator, or durable power of attorney.
2. Is the need for the exception in part based on the member living in a rural area with very limited resources?
3. How is any conflict of interest mitigated?
4. Is there other justification the member wants considered for any exception?

Benefit Provided:
Home Delivered Meals

Source:
State Plan 1915(i)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
2 per day

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:

Home-Delivered Meals service provides a participant with one (1) or two (2) meals per calendar date. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements which may not compromise a full nutritional regimen. The meals are prepared elsewhere and delivered to a participant's residence.

The need for Home Delivered Meals is determined through the STEPS assessment and person-centered planning process and documented in the participant's individualized STEPS Service Plan. The need for Home Delivered Meals is evaluated with the need for PAS to determine if home delivered meals may reduce the need for hands-on services.

Only participants who are assessed to meet criteria determined through assessment and the person centered planning process are eligible to receive these services. Participants must have a physical or intellectual/developmental disability and need physical assistance with ADLs or IADLs. Participants must demonstrate needing support for at least two ADLs per the assessment process. Home Delivered Meals are only provided in settings that comply with the home and community based services (HCBS) settings requirements.

Home Delivered Meals cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Agencies who are approved and a Medicaid-enrolled nutrition provider agency.

Benefit Provided:
Personal Emergency Response System (PERS)

Source:
State Plan 1915(i)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
2 PERS installations per year

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:

Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable participants to secure help in an emergency. The system is connected to the participant's telephone and programmed to signal a response center once the "help" button is activated. The participant may wear a portable "help" button to allow for mobility. PERS is limited to those individuals who:
1. Are alone for significant parts of the day, AND
2. Have no regular attendant (formal or informal) for extended periods of time, AND
3. Who would otherwise require extensive routine supervision.

The PERS system has a back-up battery that is activated if an emergency situation develops. The back-up battery will activate if there is interference with the landline and connection through the cell phone will remain as long as the cell phone towers are intact. If the system is not functioning properly, the provider will attempt to contact the participant through the PERS system. If unable to communicate with the participant, the provider contacts the participant-selected responders to contact with the participant in a 15-20-minute window. If the PERS provider is unable to reach the responders, then the provider will contact 911/EMS to check on the unresponsive participant. In addition, the PERS system should be checked once a month to ensure that it is functioning properly, and the back-up battery is functional. Participants have the ability to turn off/unplug the PERS system; however, turning off the system will trigger an alert to the PERS provider. The provider will follow up with the participant to ensure his/her health and welfare. The PERS provider must receive permission from the participant for the use of the device in the home.

PERS Installation is the placement of electronic PERS devices in a participant's residence. These participants have met the assessed need of a Personal Emergency Response System.

The need for PERS is evaluated with the need for PAS to determine if PERS may reduce the need for hands-on services.

Only participants who are assessed to meet criteria determined through assessment and the person centered planning process are eligible to receive these services. Participants must have a physical or intellectual/developmental disability and need physical assistance with ADLs or IADLs. Participants must demonstrate needing support for at least two ADLs per the assessment process. PERS are only provided in settings that comply with the home and community based services (HCBS) settings requirements.

PERS cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: PERS installation provider who meets the following:
Must be an enrolled Medicaid provider.
Must conform to industry standards and any federal, state, and local laws and regulations that govern this service.
The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

All HCBS providers are required to pass background checks consistent with the Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Remove

Benefit Provided:
Medication Reminder Dispenser

Source:
State Plan 1915(i)

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
1 installation per year

Duration Limit:
Non

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:

Medication Reminder Services provides a scheduled reminder to a participant when it is time for the participant to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the providers system.

Medication Reminder/Dispenser is a device that houses a participant's medication and dispenses the medication with an alarm at programmed times.

Medication Reminder/Dispenser Installation is the placement of the Medication Dispenser in a participant's home.

The need for Medication Reminder is evaluated with the need for PAS to determine if Medication Reminder Services may reduce the need for hands-on services.

Only participants who are assessed to meet criteria determined through assessment and the person centered planning process are eligible to receive these services. Participants must have a physical or intellectual/developmental disability and need physical assistance with ADLs or IADLs. Participants must demonstrate needing support for at least two ADLs per the assessment process. Medication Reminder Services are only provided in settings that comply with the home and community based services (HCBS) settings requirements.

Medication Reminder Services cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Any company providing medication reminder services per industry standards is eligible to contract with KanCare as a Medication Reminder Services.

Medication Reminder Service providers must provide appropriate training to their staff on medication

administration and dispensing of medication.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Remove

Benefit Provided: Assistive Services

Source: State Plan 1915(i)

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: See Other below

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:

Assistive Services includes equipment and product systems that are medically necessary, increase health, safety, independence, and employability and are not covered by the Kansas Medicaid State Plan.
The need for Assistive Service is determined through the STEPS assessment and a person-centered planning process and documented in the participant's individualized STEPS Service Plan.
Each Assistive Service request is reviewed on a case-by-case basis, taking into consideration medical necessity, appropriateness and cost-effectiveness. The request is then approved or denied by the STEPS Program Manager. Assistive Services has an annual cap of $7,500 which is combined with environmental and vehicle modifications, but that can be exceeded based on medical necessity. Participants are notified of the dollar limit through the service plan development process where it is determined if that amount may need to be exceeded if additional modifications or assistive services are needed to maintain community placement safely. Limits are designed to be able to enable the person to live and work in the community.

Assistive Services cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Durable Medical Equipment (DME) vendors, dentists, orthotics and prosthetics vendors, Community Developmental Disability Organizations (CDDOs) and affiliates of CDDOs, Centers for Independent Living (CILs), and licensed Home Health Agencies. All providers must be approved by the STEPS Program Manager. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding. Providers must meet standards to operate under the state plan, or under any of the KS 1915(c) waivers.

Remove

Benefit Provided: Vehicle Modifications

Source: State Plan 1915(i)

Authorization: Yes

Provider Qualifications: Other

Amount Limit:
See Other below

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:

Vehicle modifications are those services which meet a participant's assessed need or otherwise enhancing the participant's ability to live independently in his/her home and community through the use of adaptive equipment such as modifications like van lifts or other vehicle modifications.

Vehicle Modifications
1. Vehicle modifications must meet engineering and safety recognized by the Secretary of the U.S. Department of Transportation.
2. Vehicle modifications can only be installed or done to vehicles owned or leased by the participant.

Each Vehicle Modification request is reviewed on a case-by-case basis, taking into consideration medical necessity, appropriateness and cost-effectiveness. The request is then approved or denied by the STEPS Program Manager. Vehicle Modifications have an annual cap of $7,500 which is combined with Assistive services and environmental modifications, but that can be exceeded based on medical necessity. Participants are notified of the dollar limit through the service plan development process where it is determined if that amount may need to be exceeded if additional modifications or assistive services are needed to maintain community placement safely. Limits are designed to be able to enable the person to live and work in the community.

Vehicle Modifications cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications:
1. Contractors shall affiliate with a local Center for Independent Living.

2. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

3. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Benefit Provided:
Community Service Coordination - STEPS

Source:
State Plan 1915(i)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
10 hours per month

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:

Community Service Coordination includes assisting participants to make program choices, locate and direct services, develop and obtain approval for Emergency Back-Up Plans, perform fiscal management responsibilities, and complete paperwork; monitoring services and progress to complete goals; requesting and increase or decrease of services from the STEPS Program Manager; communicating progress and concerns with MCO care coordinators and Employment Specialists; linking and referring participants to community resources and non-Medicaid supports such as education, employment, and housing. Community Service Coordinators (CSC) must provide conflict-free service coordination.
The limit of 10 hours/month may be exceeded based on medical necessity.

Community Services Coordination cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Community Developmental Disability Organizations (CDDOs), CDDO Affiliates, Community Mental Health Centers (CMHCs), CMHC Affiliates, Centers for Independent Living (CILs), Accredited Clubhouse Models, Brain Injury HCBS providers, and religious based organizations. All providers must be approved by the STEPS Program Manager. Any provider listed must meet the requirements to participate in Medicaid either through the state plan or a waiver of the state plan.
Additional qualifications located in the STEPS program manual include:
• employee or affiliate of one of the listed organizations
• experience providing case management, Targeted Case Management, care coordination
• ability to provide conflict-free service coordination.

Benefit Provided:

Supported Employment - Indiv Supported Employment

Source:

State Plan 1915(i)

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

13.25 hours per month

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:

Supported Employment includes a number of services that assist participants in obtaining and maintaining employment, including developing relationships with community employers; coordinating with participants, family, the Community Service Coordinator, and the Pre-Vocational Services provider to determine participants interests and skills; assisting participants to locate employment; determining and requesting needed job accommodations; collaborating with Community Service Coordinators to determine when one-on-one assistance should be decreased or eliminated; trouble-shooting when problems arise; providing technical assistance as needed for participants and/or their employers; and documenting efforts. Supported Employment can involve one-on-one assistance to assist participants to become oriented to a new job, learn job responsibilities, practice work-appropriate and safe behavior, etc.

Supported Employment is provided up to13.25 hours during the first 15 months of participation in STEPS.

Following the first 15 months, the MCO care coordinator, with input from the Community Service Coordinator, will review the need for Supported Employment quarterly and reduce the number of hours, with a goal of eliminating Supported Employment entirely by the end of the second year. Supported Employment may be re-instated at some level, up to 13.25 hours, for a limited time, if participants require the service to maintain employment or learn new job responsibilities.
The need for Supported Employment is determined through the STEPS assessment and a person-centered planning process and documented in the participant's individualized STEPS Service Plan. Supported Employment is only provided in settings that comply with the HCBS settings requirements and are provided in the following situations: in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported Employment cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Provider Qualifications: Community Developmental Disability Organizations (CDDOs), CDDO Affiliates, Community Mental Health Centers (CMHCs), CMHC Affiliates, Centers for Independent Living (CILs), KS Workforce Centers, Accredited Clubhouse Models, Brain Injury HCBS providers and religious based organizations. All providers must be approved by the STEPS Program Manager. The provider's employee must have experience providing employment support for individuals with disabilities and their employers, knowledge of the local job market and local employers, and certification/training in any of thespecified employment models.

Benefit Provided:

Source:

Remove

Authorization:

Other

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

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

☑ 2. Essential Health Benefit: 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

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

Benefit Provided: Inpatient Hospital Services

Source: State Plan 1905(a)

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:

Remove

Benefit Provided: Physicians' Services - Inpatient

Source: State Plan 1905(a)

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:

Remove

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

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.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: 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)
Remove

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:

Add

Alternative Benefit Plan

Collapse All ☐

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

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Community Psychiatric Support and Treatment-Rehab.

Source: State Plan 1905(a)

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:

Remove

Benefit Provided: Mental Health Inpatient Services

Source: State Plan 1905(a)

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.

Remove

Benefit Provided: Substance Abuse Outpatient Services-Rehab

Source: State Plan 1905(a)

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:

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.

Remove

Benefit Provided:

Substance Abuse Inpatient Hospital Services

Source:

State Plan 1905(a)

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.

Remove

Benefit Provided:

Psychosocial Rehabilitation

Source:

State Plan 1905(a)

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

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed 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.

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

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Physical Therapy and Related Services: PT
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
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.

Remove

Benefit Provided: Physical Therapy and Related Services: OT
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
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.

Remove

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

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.

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

☑ 8. Essential Health Benefit: 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

■ 9. Essential Health Benefit: 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

10. Essential Health Benefit: 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

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

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

Base Benchmark Benefit that was Substituted:	Source:	
Prim. Care Visit to Treat Injury or Illness - dup	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:	Source:	
Specialist Visit - duplication	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:	Source:	
Other Practitioner Office Visit - duplication	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:	Source:	
Out Pt Fac. Fee(e.g., Amb. Surg. Ctr.) - duplicate	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:	Source:	
Out Pt Surg. Phys./Surg. Svs. - duplication	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:	Source:	
Out Pt Fac. Fee/Abortion - duplication	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 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.

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)- duplicate
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
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 (Abortion) is mapped to EHB 3, Physicians' Services-Inpatient and

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

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 - 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:
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
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 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.

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 Assistance Services, home delivered meals, PERS, and medication dispensers-STEPS in EHB 1 are substituted for Infertility Treatment. Actuaries have determined the cost of Personal Assistance Services along with other services listed - STEPS exceeds the cost of Infertility Treatment.

Base Benchmark Benefit that was Substituted: Donor search - 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:

Community Service Coordination - STEPS in EHB l is substituted for Donor Search. Actuaries have determined the cost of Community Service Coordination - STEPS exceeds the cost of Donor Search.

Base Benchmark Benefit that was Substituted: Biofeedback for urinary incontinence - substituted

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:

Assistive Services, home and vehicle modifications -STEPS in EHB 1 are substituted for Biofeedback for Urinary Incontinence. Actuaries have determined the cost of Assistive Services-STEPS exceeds the cost of Biofeedback for Urinary Incontinence.

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

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:

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.

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: 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:

Supported Employment - Individual Employment Support Services in EHB l is substituted for Infertility Treatment. Actuaries have determined the cost of Supported Employment - Individual Employment Support Services exceeds the cost of Infertility Treatment.

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

☒ 13. 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

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

Alternative Benefit Plan

☒ 15. 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 ☐

Remove

Benefit Provided: Nursing Facility Services

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

Remove

Benefit Provided: Peer Support-Rehabilitation

Source: State Plan 1905(a)

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.

Remove

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 "Reevaluation

for the need of crisis services is to be completed by a QMHP every 72 hours or more frequently as needed."

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: One year postpartum coverage

Scope Limit: Services as specified in the Medicaid State Plan. Pregnancy related and postpartum services for twelve months after the pregnancy ends.

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)

Remove

Authorization: Other

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.

Benefit Provided: Eyeglasses
Source: State Plan 1905(a)
Remove

Authorization: Retroactive Authorization
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 per year.

Benefit Provided: Health Homes- Serious Mental Illness
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 Medicaid State Plan
Other:
Meet Health Homes (OneCare Kansas)- SMI eligibility criteria as described in Medicaid State Plan

Benefit Provided: Health Homes - Asthma
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:
Meet Health Homes (OneCare Kansas) eligibility criteria: Asthma and at risk of developing another chronic

condition -
Diabetes, Hypertension, Cardiovascular disease, COPD, Metabolic Syndrome, Mental illness, Substance use disorder, Morbid Obesity, Tobacco Use or exposure to second hand smoke.

Remove

Benefit Provided:
Qualified Clinical Trials - Routine Patient Costs

Source:
State Plan 1905(a)

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Services as specified in Medicaid State Plan

Duration Limit:
None

Scope Limit:
Services as specified in Medicaid State Plan

Other:
In response to the Consolidated Appropriations Act, 2021 (CAA), the new mandatory benefit to cover routine patient costs for services furnished in connection with participation in qualifying clinical trials.

Remove

Benefit Provided:
CCBHC

Source:
State Plan 1905(a)

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Services as specified in Medicaid State Plan

Duration Limit:
None

Scope Limit:
Services as specified in Medicaid State Plan

Other:

Remove

Benefit Provided:
SUPPORT Act MAT

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Services as specified in Medicaid State Plan

Duration Limit:
None

Scope Limit:
Services as specified in Medicaid State Plan

Other:
MAT is provided as defined in the approved state plan 3.1-A and, if applicable, 3.1-B pages.

MAT is provided in accordance with 1905(a)(29) for the period ending September 30, 2025.

Benefit Provided: Pre-Vocational Services

Source: State Plan 1915(i)

Remove

Authorization: Other

Provider Qualifications: Other

Amount Limit: 34 hours

Duration Limit: See Other below

Scope Limit: See Other below

Other:

Pre-Vocational Services are designed to lead to integrated competitive employment by assisting participants to determine individualized vocational goals, develop or re-establish employment related skills, and participate in internships or work experiences. Services are intended to provide learning and work experiences where the participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Billable services include career exploration, workrelated skills training, and work experience. Pre-Vocational Services are provided for an established period of time; this is not an ongoing service. Participants and their providers must establish goals in the service plan, and providers must document progress toward achieving these goals.

The need for Pre-Vocational Services is determined through the STEPS assessment and person-centered planning process and documented in the participant's individualized STEPS Service Plan.

Pre-Vocational Services are only provided in settings that comply with the HCBS settings requirements. Pre-Vocational Services cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Community Developmental Disability Organizations (CDDOs), CDDO Affiliates, Community Mental Health Centers (CMHCs), CMHC Affiliates, Centers for Independent Living (CILs), accredited Clubhouse Models, KS Workforce Centers, Brain Injury HCBS providers, and religious-based organizations. All providers must be approved by the STEPS Program Manager. The provider's employee must have experience providing pre-vocational services for individuals with disabilities.

Benefit Provided: Independent Living Skills Training

Source: State Plan 1915(i)

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: 34 hours

Duration Limit: See Other below

Scope Limit: See Other below

Other:

Independent Living Skills (ILS) Training is designed to improve participant’s ability to live as

independently as possible at home and in the community using existing community resources. The provision of ILS Training may reduce or eliminate the need for Personal Assistance Services and/or Transportation. ILS Training is provided for an established period-of-time and is not ongoing.
The need for ILS Training is determined through the STEPS assessment and person-centered planning process and documented in the participant's individualized STEPS Service Plan. The limit of 34 hours may be exceeded based on medical necessity by the STEPS Program Manager.

ILS Training is only provided in settings that comply with the HCBS settings requirements.
ILS Training cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Community Developmental Disability Organizations (CDDOs), CDDO Affiliates, Community Mental Health Centers (CMHCs), CMHC Affiliates, Centers for Independent Living (CILs), Accredited Clubhouse Models, KS Workforce Centers, Brain Injury HCBS providers and religious-based organizations. All providers must be approved by the STEPS Program Manager. The provider's employee must have experience providing independent living skills training for individuals with disabilities.

Benefit Provided:
Transportation Services (non-Medical)

Source:
State Plan 1915(i)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
10 hours per week

Duration Limit:
None

Scope Limit:
See Other below

Other:
Transportation to and from job interviews, work and essential locations such as grocery stores and banks. Transportation to and from medical appointments is considered Non-Emergency Medical Transportation (NEMT) and must be obtained from participants' MCO.

The need for transportation is determined through the STEPS assessment and person-centered planning process and documented in the participant's individualized STEPS Service Plan. The limit of 10 hours per week may be exceeded based on medical necessity by the STEPS Program Manager.

Transportation services cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications: Personal assistants or other individuals selected by participants, agencies or companies providing specialized transportation, companies that provide non-specialized transportation such as buses, taxis, Uber, etc. The driver must have a driver's license and a review of their driving record.

Benefit Provided:
Fiscal Management Services

Source:
State Plan 1915(i)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See Other below

Other:
Fiscal Management Services (FMS) assist participants who are self-directing their services, including processing all employer, employee, and vendor paperwork; processing payroll/paying invoices;withholding federal and state taxes and making tax payments to appropriate tax authorities; and performing fiscal accounting and providing expenditure reports.

Provider Qualifications: Organizations interested in providing Financial Management Services (FMS) are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment to provide the service. The agreement identifies the programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually, and approval is subject to satisfactory completion of the required Generally Accepted Accounting Principles (GAAP) audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have a prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

For new organizations seeking to be a FMS provider, the FMS provider agreement and accompanying documentation are reviewed by KDADS and/or their designee to ensure that all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS, or designee.

Benefit Provided:
Environmental Modifications

Source:
State Plan 1915(i)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
See Other below

Duration Limit:
None

Scope Limit:
See Other below

Other:
Environmental modifications are those services which meet a participant's assessed need by modifying or improving a participant's home through home modifications or otherwise enhancing the participant's ability to live independently in his/her home and community through the use of adaptive equipment such as modifications like van lifts or other vehicle modifications.

Home Modifications
1.Home modifications may not add to the total square footage of the home except when necessary to complete the modification. Examples include increase in square footage to improve entrance/egress in a residence or to configure a bathroom to accommodate a wheelchair.
2.Home modifications may only be purchased in rented apartments or homes when the landlord agrees in

writing to maintain the modifications for a period of not less than three years and will give first rent priority to tenants with physical disabilities.
3. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Each Environmental Modification request is reviewed on a case-by-case basis, taking into consideration medical necessity, appropriateness and cost-effectiveness. The request is then approved or denied by the STEPS Program Manager. Environmental Modifications have an annual cap of $7,500 which is combined with Assistive services and vehicle modifications, but that can be exceeded based on medical necessity. Participants are notified of the dollar limit through the service plan development process where it is determined if that amount may need to be exceeded if additional modifications or assistive services are needed to maintain community placement safely. Limits are designed to be able to enable the person to live and work in the community.

Environmental Modifications cannot be provided when participants are receiving these services from other Federal/State entities, e.g., Vocational Rehabilitation.

Provider Qualifications:
1. Contractors shall affiliate with a local Center for Independent Living.

2. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, then a letter from the county or city must be provided stating licensure or certification is not required.

3. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

Add

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.20190808

Alternative Benefit Plan

State Name: Kansas Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

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):

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.

Alternative Benefit Plan

- ☑ 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.
- ☑ 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).

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

State Name: Kansas | Attachment 3.1-L- | OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

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:

- [x] Managed care.
  - [x] 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

- [x] 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's Medicaid managed care program, "KanCare", was initially implemented in January of 2013 under the authority of a Section 1115 demonstration, which is currently approved through December 31, 2023. In December 2022, Kansas submitted an amendment and five-year renewal of the KanCare 1115 demonstration for the period January 1, 2024 through December 31, 2028. This amendment proposes to transition the managed care authority for KanCare from the 1115 to a 1932(a) state plan amendment and a section 1915(b) waiver and authority for STEPS from the 1115 to an ABP.

STEPS participants are enrolled with the current MCOs, and the ABP population will continue to be enrolled with the current MCOs through the end of the contract term. The State's current MCO contracts are effective until December 31, 2024. The State intends to release a Request for Proposal (RFP) in the fall of 2023 to select MCOs for service delivery effective January 1, 2025. The State will work with the MCOs and stakeholders to ensure a smooth transition of the ABP population to any new MCOs.

The ABP population will be enrolled in MCOs similar to other Medicaid/CHIP beneficiaries and will receive all MCO communications, a member handbook, enrollment materials, etc. The MCOs will be required to identify eligible KanCare members who are interested in employment and refer them to STEPS. The MCOs will contract with a fiscal management services (FMS) provider, which will contract with community providers to provide STEPS services. The MCOs will be responsible for care coordination for STEPS ABP participants, including conducting needs assessments, assisting participants to locate a community service coordinator, and approving person-centered service plans.

MCO: Managed Care Organization

Alternative Benefit Plan

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: Dec 14, 2023

Describe program below:

The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This is accomplished by providing the right care, in the right amount, in the right setting, at the right time. As noted above, KanCare is currently authorized under a Section 1115 demonstration, but Kansas intends to transition the managed care authority for KanCare from the 1115 to a 1932(a) state plan amendment and a Section 1915(b) waiver. Beneficiaries participating in STEPS will be included in the Section 1915(b) waiver.

Kansas currently contracts with three MCOs to provide integrated physical health, behavioral health, and long-term services and supports to nearly all Medicaid/CHIP beneficiaries. As noted above, the State intends to issue an RFP in the fall of 2023 to procure MCOs for service delivery effective January 1, 2025.

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare. KDHE maintains financial management and contract oversight of the KanCare program while KDADS administers the 1915(c) HCBS waiver programs and mental health and substance abuse services and operates the state hospitals and institutions.

☐ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

- ◉ Competitive procurement method (RFP, RFA).
- ○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

MCO service delivery is provided on less than a statewide basis. No

#type# Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: No

General #type# Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- (•) Mandatory participation.
- ( ) Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Participants are defaulted to an MCO, but given 90 days to make a change. Yearly, during the open enrollment process, participants are given 90 days to make a new MCO choice or to remain with the current MCO. Participants are also able to change MCOs outside of open enrollment for a good cause reason as defined in 42 CFR 438(d)(2). Native Americans can opt out of managed care at any time.

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (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.20181119

Alternative Benefit Plan

State Name: Kansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

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 STEPS. 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:

V.20160722

Alternative Benefit Plan

State Name: Kansas Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

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.

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

State Name: Kansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: KS - 23 - 0026

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.

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.20160722