Medicaid Managed Care Contract Matrix: Kansas

Programmatic Element	Standards	Source
Program Name	KanCare	
Date of Transition	The state received CMS approval to move 1915 (c) waiver services for individuals with I/DD into KanCare in 2014.	CMS Approves Kansas' Inclusion of I/DD Waiver Services in Managed Care Demonstration, ANCOR
Total Enrollment	8,954 (individuals with I/DD)	Current Landscape: Managed Long-Term Services and Supports for People with I/DD, ANCOR, 2018.
Enrollment Type	Mandatory for most; voluntary for dual eligibles, foster care children, and children with disabilities.	5.1.1 (RFP)
Plans Operating in the State	Aetna, Sunflower Health (subsidiary of Centene), and UnitedHealthcare	Choosing a KanCare Health Plan, KanCare Medicaid for Kansas
Authority for Managed Care	1115 waiver authority; operating concurrently with the state's 1915 (c) home and community based services (HCBS) waivers	Kansas 1115 Waiver Special Terms and Conditions
Eligibility	Most Medicaid beneficiaries, including individuals on the Intellectual Disabilities/Developmental Disabilities waiver and the Technology Assisted waiver.[1]	Kansas 1115 Waiver Special Terms and Conditions
Benefit Design	MCOs agree to assume responsibility for all physical health, behavioral health, HCBS, and long term care services and supports (LTSS) for members.	RFP Attachment C (Services)
Plan Type	Traditional managed care organizations (MCOs). The health plans operate statewide and enroll all eligible populations, the plans are	

[1] The Intellectual/ Developmental Disabilities waiver is for Medicaid-eligible individuals ages five and older who have an intellectual disability that began before the age of 18; have a diagnosis of a developmental disability that began before the age of 22, or are eligible for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Technology Assisted (TA) KS-4165 waiver is for Medicaid-eligible individuals ages zero to 21 who are chronically ill or medically fragile and dependent on a ventilator or medical device to compensate for the loss of vital bodily function. Eligible individuals require substantial and ongoing daily care by a nurse or comparable to the level of care provided in a hospital setting to avert death or further disability. Upon aging out, these individuals have the option to transition to the HCBS physically disabled, I/DD, or TBI waiver, if they meet the waiver criteria.

	not specific to individuals with I/DD.	
Integration with Medicare	Minimal integration; as part of service coordination requirements, MCOs must ensure that Medicare-funded services are coordinated and "maximized for populations including HCBS waiver populations."	5.4.1 (RFP)
Residential Services	State hospitals for individuals with I/DD that are ICFs/IID are carved out of KanCare. However, private ICF/IID facilities are carved in. When a beneficiary who resides in the community has been recommended for placement into an ICF/IID or nursing facility, the state must review and approve the placement before the beneficiary can be admitted into the ICF/IID or nursing facility to ensure that members with I/DD are not improperly placed in institutions.	RFP Attachment C (Services) Kansas Medicaid: A Primer 2019
Care Coordination Model	***Note:*** *Due to pushback from stakeholders and legislators, many of the care coordination contract provisions included below (including the role of community service coordinators) have not been implemented for individuals on the I/DD waiver. Instead, in addition to their MCO-assigned service coordinators, individuals on the I/DD waiver retain access to their waiver targeted case managers. According to interviewed stakeholders, these contract changes were memorialized in the KanCare 2.0 contract amendments with the MCOs, which were not publicly available at the time of this review.* *Service coordination generally*—MCOs are responsible for providing service coordination for members across all providers and settings. Plans must develop and implement a comprehensive service coordination program that meets the following goals: • Supports person-centered care • Intervenes along a continuum of need from preventive care to addressing acute, complex, and chronic needs • Integrates behavioral health, physical health, and LTSS needs with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders (SUDs) • Improves health outcomes for the entire population • Addresses the social determinants of health and independence, including housing, adequate nutrition, adequate environmental conditions, transportation and other social determinants • Increases access to community-based LTSS • Allows for maximum access to community supports • Supplements but does not supplant natural supports • Provides for conflict-free case management, service delivery, and assessment as required by federal and state regulations • Ensures that all populations, depending on their needs, receive the appropriate level of service coordination • Consists of case management and service coordination functions and activities • Ensures appropriate face-to-face monitoring or telehealth, depending on needs of the member	5.4 (RFP) RFP Attachment L – Service Coordination Matrix OneCare Kansas Program Manual

To meet these goals, a plan's service coordination program must, at a minimum, including the following elements:

- Processes for screening and assessing members (MCOs must make three attempts via phone and then follow up by mail within 10 business days from the date of enrollment for new members to complete a health screening and health risk assessments. If unable to reach the member, plans must attempt screen again, at a minimum, every 90 days)
- Processes for identifying and enrolling members into the service coordination program
- Person-centered service planning process
- Monitoring and oversight processes of member's services and health and welfare
- Processes for transitions of care
- Information and referral processes
- A process for effectively communicating with the member, their family, primary care provider (PCP), other providers, and members of the member's interdisciplinary team
- The provision of trauma-informed care and other evidence-based practices as appropriate
- Subcontracting with local entities for the provision of community service coordination
- A process for establishing the necessary permissions from the individual to coordinate care among different providers, and establishing the required federal agreements to address protected health information (PHI)
- A process to assure referrals for medically necessary, specialty, secondary, and tertiary care, and a person designated as primarily responsible for coordinating the health care services furnished to the member
- A process to assure the provision of care in emergency situations, including an educational process to help assure that members know where and how to obtain medically necessary care in emergency situations

Populations eligible for care coordination—MCOs are required, at a minimum, to enroll those populations:

- Individuals on the 1915 (c) waiver or on a waiver waiting list
- Individuals who are institutionalized in a NF, ICF/IID or hospital, psychiatric residential treatment facility, psychiatric hospital, or other institution
- Youth (birth up through age 21) with intensive behavioral health needs
- Youth who are in and out of home placement through the foster care system
- Adults with behavioral health needs
- Individuals with chronic and/or complex physical and/or mental health conditions
- Individuals participating in the Work Opportunities Reward Kansans (WORK) program or other employment programs
- Other individuals who the MCO determines would benefit from service coordination. MCOs must use information regarding social determinants of health and independence (such as housing instability, food insecurity, or unemployment/underemployment) to identify the other individuals who would benefit from service coordination. Plans are

	required to submit the criteria used to identify other members to receive service coordination to the state for review and approval. *Plan of care*—MCOs must develop a plan of care for all members receiving service coordination, which outlines strategies to meet goals and interventions selected by the member and member's team. Members on the HCBS waiver, children in foster care, and members with behavioral health needs must also participate in a person centered service planning (PCSP) process that's compliant with federal and state PCSP policies. *Community service coordinators*—MCOs must subcontract with local entities to provide service coordination in the community; these subcontractors are known as community service coordinators. For individuals on the I/DD waiver, the community service coordinators are responsible for the following: • Development, implementation, and monitoring of the PCSP and plan of service • Choice counseling (excluding counseling provided to a beneficiary related to MCO selection) • Completion of health screen, health risk assessment, and needs assessments • Implementation of the treatment plan component of PCSP and plan of service, as appropriate • Member contacts and home visits • Linkage and referral to community resources and non-Medicaid supports • Health and safety monitoring • Support for education, employment and housing, including, but not limited to, making referrals, advocacy and follow-up • Education of the member about self-direction and the WORK program and other employment programs and support of the member who chooses to self-direct certain HCBS and WORK services • Serving as the single point of contact for the member *Service coordinators*—The MCO's service coordinators assigned to individuals on the I/DD waiver are responsible for approval of the PCSP and coordination of physical, behavioral, LTSS, and transportation services. *Service coordinator qualifications*—Both community service coordinators and plan-employed service coordinators serving members with an LTSS need must have at least least a bachelor's degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a registered nurse; have at least one year of experience working with individuals with LTSS needs, and if working with a specific waiver population, at least one year's experience working directly with that population. Full-time experience in the field of DD services may be substituted for the degree at the rate of six months of full-time experience for each missing semester of college for service coordinators working with individuals with I/DD. Additionally, all service coordinators providing services to individuals with I/DD must meet the state's requirements for licensing of DD providers of	

community services (i.e., a minimum of six months of full-time experience in the field of human services and either a bachelor's degree or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of six months of full-time experience for each missing semester of college).

Plans are responsible for maintaining a single MCO point of contact for the community service coordinators, establishing a protocol for the transmission of requested data, information, and reports, and responding to requests from the community service coordinators for assistance or support in a timely manner. Plans must develop a contingency plan for when there are short-term gaps in community service coordination capacity and must notify the state upon activation of the contingency plan.

The state has a tier model of care coordination that stratifies groups of members based on their needs and places requirements on MCOs that correspond with those members' needs. All members on an HCBS waiver are assigned to level III: chronic long-term needs level of service coordination; level III requires the plan to make at a minimum monthly telephonic contact and a minimum of a face-to-face visit every three months.

MCOs may use a team approach to care coordination where non-clinicians perform certain tasks, including, but not limited to, confirmation of provider appointments, scheduling home visits, arranging transportation, and facilitation of distribution of the service plan to the member and providers. MCOs may also provide or subcontract with a certified peer support provider or a positive certified behavioral support facilitator as part of the service coordination team.

Additional requirements for special populations—MCO must meet additional specific requirements related to service coordination for special needs populations. For individuals in institutional settings, MCOs must:

- Participate in, at a minimum, one service coordination meeting with the member, their family, and the facility staff at least annually.
- At least annually, evaluate if the member's needs can be met in a less restrictive environment that includes assessing the member's interest in and ability to transition to the community and determine if the member has an interest in transitioning to a community setting. Requests for evaluations may also come from the ombudsman (KanCare or LTC), member, legal guardian, or other representative.
- Develop a transition plan to help support the transition to a less restrictive environment as appropriate.
- Ensure supports are in place prior to the discharge and transition to new setting.
- Assist with helping the member relocate to another facility if they express a desire to move or the quality of the current facility places a member's health and welfare at risk and ensuring all the necessary supports are available for a successful transition.

- Monitor the success of the member's community transition and ensure if enrolled in a HCBS program that the new setting is compliant with federal HCBS regulations.

For individuals on an HCBS waiver and enrolled in WORK or other employment programs, MCOs must:

- Provide all members receiving HCBS waiver services with the appropriate notice for any adverse benefit determination
- Ensure that the member's PCSP or plan of service supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- Timely recommend voluntary and involuntary closure for HCBS waiver services to the appropriate state agency using the appropriate established notification process
- Document the termination of services due to the inability to contact an LTSS member regarding initial or annual assessments for services and supports according to the state's notification of closure policy

Care transitions—MCOs must manage transitions of care between settings in order to prevent unplanned or unnecessary hospital readmissions, ED visits, and/or adverse outcomes, including from ICF/IID to community, member's assignment to an HCBS waiver, or transfer from one HCBS waiver to another. As part of the care transitions process, MCOs must, at a minimum:

- Develop a method for evaluating risk of hospital readmission in order to determine the intensity and urgency of follow up required for the member after the date of discharge.
- Regularly collaborate, communicate, and coordinate with the member, their families/support persons/guardians, ED, LTSS, physicians, nurses, social workers, discharge planners, the discharging facility, service providers, and schools as appropriate.
- Establish a single point of contact for the member's transition activities.
- Ensure that timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between internal MCO's departments and between care settings, as appropriate.
- Make referrals to, work with, and leverage resources from any existing transition programs as appropriate.
- Evaluate a member's need for LTSS and pursue the least restrictive environment for the individual, taking into consideration the member's preferences. MCOs must make referrals for HCBS waiver eligibility and/or NF placement to the appropriate entities.
- Participate in discharge planning activities with the facility, including making arrangements for safe discharge placement, facilitating clinical hand-offs between the discharging facility and the MCO, and ensure adequate housing and income support are available to the member.
- Provide sufficient information and support to ease the transition by addressing the member's understanding of medications,

	self-management, rehabilitation activities, LTSS, employment, independence, etc. • Schedule appointments and follow up with members if appointments are missed. • Evaluate the need to develop or revise the PCSP or plan of service in collaboration with the member, providers, caregivers, or other appropriate entities, with the member's consent. • Develop, or assist in the development of, or obtain a copy of an existing discharge/transition plan, and ensure that the transition/discharge plan and post discharge services are integrated into the member's PCSP or plan of service. *Service collaborative*—MCOs must participate in a state-chaired KanCare service coordination collaborative. The purpose of the collaborative is to address questions and issues MCOs encounter in implementing the service coordination program, ensure the program is being implemented consistently throughout the state, and share service coordination best practices and resources. *Looking ahead:* the state is preparing to launch the OneCare Kansas (OCK) care coordination program in Medicaid in April 2020. OCK is a Medicaid health home model that will provide care coordination to individuals with a behavioral health diagnosis or chronic physical health conditions. The state intends to add additional target population to the OCK state plan amendment in the future.	
Staffing Requirements	MCOs are required to have the following LTSS-dedicated staff: • A full-time L*TSS clinical officer/medical director* who is licensed and board certified in geriatrics or a gerontological nurse practitioner, exclusively dedicated to the KanCare contract and has at least five years of experience in directing health care services for frail elderly or individuals of any age with physical or individuals with I/DD. This person must oversee and be responsible for all primary and physical and behavioral health services provided to individuals receiving LTSS, and to comparable populations enrolled in KanCare, and all clinical activities pertaining to the operation of LTSS programs and services, including preventive care and the management and coordination of chronic conditions and physical health needs, and the integration and coordination of primary and other physical health services for members receiving LTSS. • A full-time *LTSS director/manager* dedicated to the KanCare LTSS initiatives including care coordination efforts, housing, employment, transportation and community integration activities required for a high performing LTSS system. This position works closely with the medical officers, quality director and other clinical partners to provide direction to improve coordination and implement community-based and institutional initiatives, (e.g., programs designed to address transitions from long-term institutional settings or social determinants of health and independence). • Plans must identify one or more *dedicated LTSS and behavioral health provider representatives*. These representatives are responsible for internal representation of providers' interests including, but not limited to, contracting, service authorizations, claims processing, and other LTSS and behavioral health provider needs. These providers conduct ongoing communications with LTSS and behavioral health providers through provider forums, webinars, dedicated toll-free LTSS provider telephone lines and other means to ensure resolution of issues that include but are not limited to:	5.17 (RFP)

	enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes. • A full-time *housing specialist* exclusively dedicated to overseeing housing services and supports for LTSS and behavioral health programs and services. This person must have at least three years of experience in assisting the elderly and persons with disabilities to secure accessible, affordable housing through federal and local programs. The housing specialist is responsible for working with housing programs to help develop and access affordable housing services for members receiving LTSS, educating and assisting care/support coordinators regarding affordable housing services for KanCare members, and liaison with state housing coordinators and housing specialists within each community mental health center on Kansas' broader housing strategy and initiatives. The housing specialist will work with the state to ensure that community providers are trained and achieving fidelity in evidence-based practices. • A full-time *employment services and supports coordinator* exclusively dedicated to the KanCare contract and responsible for overseeing employment services and supports for LTSS programs and services. This person must have at least three years of experience in developing employment services and supports for persons with disabilities in integrated settings. Plans must also assist the state with any new employment initiatives the state may implement, and provide ongoing leadership of employment services and supports for the plans' staff and participating providers. • At least two full-time *member advocates (one for LTSS and one for behavioral health)*, exclusively dedicated to the KanCare contract who must have at least two years of experience in a health care related field with requisite experience working with either LTSS or behavioral health populations, preferably working with low-income populations, and have demonstrated expertise in topics related to LTSS, resiliency and recovery and cultural competency.	
Dental Services	Dental services for children enrolled in KanCare are covered by the plans. MCOs can choose to provide dental services to adults as a value-added benefit. All MCOs currently contracted with the state have elected to provide annual limited coverage for preventive dental care (screenings and cleanings).	Attachment C (Services) 5.3.2 (RFP) Health Plan Highlights for 2018, Kancare
Optical Services	Covered vision services include but are not limited to: • Eye exams and glasses including for post cataract surgery • Contact lenses and replacements • Artificial eyes	Attachment C (Services)
Workforce	According to the I/DD advocacy group InterHab, organizations that provide community-based services to individuals with I/DD are facing a workforce shortage crisis of direct support professionals in the state. InterHab is advocating for legislative action.	InterHab Advocacy, 2019
Plan Rates	Kansas reimburses MCOs through capitated rates and has developed rate cells to cover all Medicaid eligible populations. All rates	5.13.2 (RFP)

	paid to MCOs must meet federal actuarial soundness requirements. Rates are risk adjusted in a budget neutral manner, which shifts funds across plans based on their population's acuity, but does not add additional funding to the rates. Rates are developed annually and are adjusted from the preceding year for inflation, trends, utilization, and policy changes and must be approved by CMS. *Encounter data*—For purposes of developing rates, MCOs must submit validated encounter data and audited financial reports in accordance with the federal regulations. MCOs are provided the right to audit case mix information and the supporting medical records and to recommend adjustments/corrections to that data; however, the state retains ultimate authority in deciding whether to implement those adjustments. *MLR*—As required by federal regulations, Kansas has imposed an MLR of 85%. MCOs that fail to meet the MLR may be required to repay funds to the state. MCOs must aggregate the data across rate cells under the contract to calculate the MLR. The MLR consists of: • Numerator: Sum of the MCO's incurred claims, activities that improve health care quality, and fraud prevention activities. The expenditures for fraud prevention activities are not to be included in the numerator until CMS adopts a standard for the private market. • Denominator: The adjusted premium revenue, which is premium revenue less the MCO's federal, state, and local taxes and licensing and regulatory fees.	
Value-Based Payment Arrangements	MCOs are required to propose, seek state approval for, and implement VBP models and alternative purchasing strategies as part of their contract with the state. In their contract bids, MCOs were required to put forth proposals for all of the state's VBP priority areas outlined below (plans that didn't have specific proposals for some areas had to indicate so in their response). These VBP priorities include: • Alternative payment models that include quality and/or outcome measures as part of the reimbursement strategy. Such models can include episodic bundled payments, shared savings strategies with providers, or risk based payment strategies to providers capable of managing such payment arrangements. • Models to address social determinants of health and independence interventions that impact the overall health and well-being of members and result in decreased medical expenditures. • Contracting strategies to address behavioral health service needs, including mental health and addiction services. The alternative payment strategies must be designed to reduce total cost of care, and address gaps and improvement in access to services, quality of providers, incentives for "warm handoff" transitions from institutions to less-restrictive and less costly treatment programs in community-based programs and services, seamless follow-up care, and diversions from institutions, particularly ED diversion resulting in reduced inpatient admissions. • Contracting strategies to address LTSS service needs including HCBS, adult care home, and institutional services. The	5.7 (RFP)

	alternative payment strategies must address gaps and improvement in access to services, quality of providers, incentives for transitions from institutions to community-based programs and services, diversions from and significant reduction in the reliance of institutions for treatment, ensuring choice of in-home vs. residential services. Service focus of the strategies must include, but not limited to autism, agency directed personal care, assisted living, residential health care, home plus, I/DD residential and other community service settings. • Innovative models for integration of physical and behavioral health services. • Models to expand the use and effectiveness of telehealth strategies, including telemedicine and telemonitoring. Such models must focus on strategies to enhance access to services for rural areas, access to behavioral health services, and support chronic pain management interventions. The model contract notes that the state intends to use standardized measures and reports for VBP arrangements primarily based on nationally accepted measure sets such as HEDIS. The state reserves the right to modify metrics and reporting requirements to standardize reporting across MCOs for similar VBP arrangements.	
Employment	MCO activities under the model contract must be consistent with a number of state initiatives, including increasing collaboration with CBOs to connect members to, among other services, employment, and increasing access to and successful maintenance of competitive integrated employment. Members on the I/DD waiver can access supported employment services through the MCO. CMS has authorized the state to launch a Disability and Behavioral Health Employment Support Pilot Program (BH Pilot) under its 1115 waiver authority. The BH Pilot would enable eligible members (individuals ages 16 through 65 with an I/DD who are willing to leave their HCBS waiver and individuals who are on the HCBS waiver waitlist and are SSI eligible) to obtain and maintain employment through the following services: • Pre-vocational services (available to participants who have not or are unable to access vocational rehabilitation services) • Supported employment • Personal assistant services • Independent living skills training • Assistive technology • Transportation Under the BH Pilot, employment is defined as a minimum of 40 hours per month in a competitive, integrated setting at the federal hourly minimum wage or more. The state would make available benefit specialists to provide program guidance to potential participants and use a standardized needs assessment process to determine eligibility for the BH Pilot. Individuals on the waiver or the waiver waitlist who would choose to leave the waiver/waitlist would have the option to return to the waiver/waitlist if the employment support services proved ineffective in helping the individual obtain and maintain employment. The BH Pilot enrollment	6.4 (RFP) Kansas 1115 Waiver Special Terms and Conditions

	would initially be limited to 500 members. The state intends for the BH Pilot services to be provided exclusively as a managed care benefit. MCOs would play a role in: • Identifying eligible members who are interested in employment • Promoting the benefits of employment to members • Referring members to employment services • Reauthorizing continuation of services (e.g., 6-month increments for pre-vocational services, independent living skills training). • Providing (or paying for) community service coordination and other pilot services. Kansas intends to move forward with pilot implementation in 2021.	
Assistive Technology	Members on the I/DD waiver can access assistive technology services through MCOs. Assistive services are defined as those 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. Adaptive equipment includes durable medical equipment, van lifts, communication devices, and home modifications, including increases in square footage to improve entrance/egress in a residence or to configure a bathroom to accommodate a wheelchair. All assistive services are purchased under the member's or his or her guardian's written authority and paid to the provider and cannot exceed the prior authorized purchase amount. All assistive services are arranged by the MCO and must be subject to prior authorization. Participants have freedom to choose from all qualified providers with consideration given to the most economical option available to meet the participant's assessed needs. If a related vendor, such as a durable medical equipment provider, does not wish to contract with the MCO or the financial management services (FMS) provider, the state will provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.	Kansas - HCBS-I/DD Waiver
Utilization Management	MCOs must engage in comprehensive, integrated UM programs that utilize evidence-based practices and ensure access to all medically necessary covered services. MCOs are required to provide the Kansas medical necessity definition, medical necessity criteria, authorization policies, procedures, and any applicable practice guidelines to all affected providers and, and upon request, to members and potential members. Health plans are required to provide educational materials and webinars to providers on their UM program, offer a forum for provider suggestions for policies and procedures at least annually, and document all changes made subsequent to provider input. MCOs' UM policies, procedures, and practice guidelines must be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, consider the needs of the members, and be adopted in consultation with participating	5.8 (RFP)

providers and reviewed and updated periodically as appropriate.

Plans must monitor and evaluate the appropriateness of care and services on a monthly, quarterly, semi-annual, and annual basis. MCOs must submit the UM plan and evaluation results to the state at least annually for review. The UM evaluation must:

- Identify and describe the mechanisms to detect services that are the drivers of utilization cost and the services that are identified as being underutilized
- Identify rationale and evidence to support the decision to apply prior authorization to certain services
- Include analysis validating compliance with federal mental health parity regulations

Kansas has established specific UM requirements for members enrolled in an HCBS waiver:

- In the event that the member receiving HCBS waiver services has participated in responding/complying with the MCO's requests for re-evaluation prior to expiration of current authorization, continues to demonstrate need for services at the appropriate scope, duration and frequency, and expresses a desire to retain the current provider and service array, the MCO must ensure that HCBS services are reauthorized prior to the expiration of current authorizations in order to ensure continuity of care and stability for members and providers regarding those services. If an authorization expires, and the member has actively participated/complied with re-evaluations, the designated entity has offered impartial choice timely, and the chosen provider has complied with requested documentation submission, HCBS will be considered as authorized consistent with the previous authorization until the pending reauthorization is fully operational, and claims for services provided between authorizations will be adjudicated consistent with the claims adjudication requirements of the contract.
- MCOs must conduct prior authorization for those members receiving HCBS services in a manner that assesses both the medical and functional needs of the member, and considers whether the denial of equipment, supplies, or services would inhibit a member's community access, or the progression of the member's PCSP, if denied.
- Once the MCO has authorized HCBS, claims for the fully authorized service will be adjudicated in accordance with the claims processing guidelines and applicable member due process rights. MCOs must ensure that HCBS initial authorizations are electronically entered for delivery and billing in a timely fashion. This is defined as 99% of HCBS initial authorizations being issued within 14 business days of the initial delivery date of service into the MCO's authorization system and 95% of HCBS initial authorizations being entered into the MCO's authorization system one day prior to the first date of service delivery with the exception of: continuity of care for members transitioning from one MCO to another; members with gaps in eligibility that have been restored; members who have been emergently placed by adult protective services or other state or law enforcement agency in service on a non-business day; members who have incurred a material change in condition necessitating a change in services overnight, weekend or holiday, or other similar circumstance in which retroactive authorizations may be necessary to address the needs of the member; institutional transitions into the community; and delays in coding or correct coding as it relates to level of care. MCOs must contact the appropriate state entity when aware

	of delays in level of care coding. 100% of approved PCSP authorizations must be provided to the provider and member prior to services beginning. *Termination of HCBS wavier services*—HCBS waiver services for members on the waiver may be terminated in cases in which a member: • Has no assessed need for services upon assessment or reassessment. • Client obligation is higher than the cost of service as identified on the integrated service plan. • Has refused to pay client obligation as documented by the provider to whom the client obligation is to be paid or the financial management services (FMS) provider and verified by the service coordinator. • Has refused services and supports identified on the integrated service plan as documented and signed by the member and/or guardian. • Has been institutionalized for longer than the temporary care period of time (the month of Admission and two subsequent months) and is no longer eligible for services. • Is unable to be located or fails to respond to attempts to locate for initial or annual assessment for services. • Refuses to sign the PCSP or the plan of service. • Is no longer receiving services under the LTSS program. • Has requested termination of services. • Cannot be contacted or does not respond to reasonable attempts to contact the member as required by the notification of termination policy.	
Enrollee Protections	*Continuity of care*—Receiving MCOs must develop or attempt to develop contracts with previously utilized providers to ensure the continuity of care for members. During transitions between care settings, as appropriate, depending on the details of the member's transition, MCOs must ensure that the member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time even if that provider is not in the MCO's provider network. *Member advocacy*—Plans must eliminate barriers that prohibit or restrict advocacy for: • The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in health care decisions including the right to refuse treatment and to express preferences	5.4.11 (RFP) 5.10.1 (RFP) 5.10.12 (RFP) Kansas 1115 Waiver Special Terms and Conditions

	about future treatment decisions. *Disenrollment for inability to contact*—MCOs must document termination for the inability to contact an LTSS member regarding initial or annual assessments for services and supports. MCOs must make three attempts to contact the member, including a minimum of one home visit. All contacts must be attempted within 14 business days from the date of the initial attempt to contact the member. If unsuccessful, the MCO must notify the KanCare Ombudsman and request assistance. If all attempts to contact the member by the plan or KanCare Ombudsman prove unsuccessful, the MCO must notify the appropriate state agency, which may intervene to attempt contact with the member. All recommendations by the MCO must be approved by the state to issue a notice of action providing the member 10 days' notice of the impending closure. The notice of action must be mailed to the member's last known address. MCOs must provide the state with the appropriate notice recommendation to close the services and supports for the member. If the MCO suspects that an inability to contact a member is the result of any abuse, neglect or exploitation, the plan must make immediate referrals to the appropriate state agency for follow-up and investigation. *Member notice*—Plans must provide members with at least 30 calendar days written notice of any significant change in policies concerning members' disenrollment rights, right to change PCPs, or any significant change to any other member rights, regardless of whether the state or the MCO caused the change to take place.	
Provider Protections	*Prompt pay requirements*—MCOs may enter into any payment arrangement with providers that adequately reimburses providers for services and supports integrated, coordinated care, including shared saving arrangements, to the extent that they do not conflict with federal or state regulations. MCOs must pay all claims timely and accurately: • 100% of all clean claims (including adjustments) must be processed and paid or processed and denied within thirty 30 calendar days of receipt. • 99% of all non-clean claims (including adjustments) must be processed and paid or processed and denied within sixty 60 calendar days of receipt. • 100% of all claims (including adjustments) must be processed and paid or processed and denied within ninety 90 calendar days of receipt. *State oversight of claims denials*—If the state determines that any MCO has a pattern of inappropriately denying payments to non-participating providers, the plan may be subject to suspension of new enrollments, withholding of capitation payments, contract termination, or refusal to contract in a future time period. This applies to cases where the state has ordered payment after appeal and also to cases where no appeal has been made (i.e., the state is knowledgeable about abuse from other sources). *Benchmark rates*—The state establishes FFS per diem rates for NFs and ICF/IIDs utilizing a cost and acuity based methodology. MCOs are required to pay, at a minimum, each facility the FFS rate as established by the state. *Provider relations*—MCOs must ensure that provider calls are acknowledged within three business days of receipt, are resolved, and	5.14.1 (RFP)

	the result communicated to the provider within 30 business days of receipt. Plans must have a sufficient number of dedicated provider representatives to make office visits and train providers. Provider representatives must train providers on claim billing, Medicaid benefits, authorization requirements, grievance, appeal, and state fair hearing rights and procedures, recoupments explanation of benefits, claim reconsiderations, and claim payment/denial. MCOs must ensure that all provider offices receive one phone call/visit at a minimum per calendar year quarter. Some larger facilities/clinics may require more frequent contact.	
Network Adequacy	MCOs are required to develop, monitor, and maintain an LTSS provider network, including HCBS providers and alternative residential settings (e.g., assisting living facilities and I/DD day and residential settings) that are supported by written agreements and sufficient to provide all LTSS covered services. Plans must: • Comply with state-established provider network standards, including time and distance standards for applicable provider types covered under the contract, including time and distance standards for LTSS provider types in which a member must travel to the provider to receive services and network adequacy standards for LTSS provider types that travel to the member to deliver services and providers that require the member to move in order to receive services. • Comply with additional network adequacy metrics specific to LTSS population, as identified by the state, to demonstrate timely initiation of service and ongoing service as compared to the members' schedule for services. • Place a priority on allowing members, when appropriate, to reside or return to their own home vs. having to reside in an institutional or alternative residential setting. • Promote person-centered care through the development of services and settings that support the mutually agreed upon PCSP or plan of service through all service settings. • Develop HCBS and settings to meet the needs of members who have cognitive impairments, behavioral health needs, and other special medical needs and comply with federal HCBS setting requirements. • MCOs must directly contract with an adequate network of Kansas-based FMS providers to offer choice for members. For members self-directing their services and using a FMS provider to assist in processing claims and payments to their direct support workers, MCOs must reimburse FMS providers separately for administrative functions and direct service workers funds. • Ensure that all licensed and Medicaid-certified NFs are offered inclusion in the MCO's provider network. The plans can evaluate each provider's continued network enrollment based on the assessment of quality and performance outcomes. A plan must request approval from the state if it wants to terminate the contract of a NF for poor quality of care and not meeting performance outcomes. MCOs must, in their request to the state, indicate the reasons for the termination, remedial actions that have been taken, preliminary plan on where residents would be transferred, impact of the transfers on the NF, and local community, and any other information that the MCOs believe is relevant. Provider network agreements must only	5.5.6 (RFP) Kancare Network Adequacy Standards, April 2019

	be with NFs certified under Medicaid but MCOs are expected to help NFs move to both Medicare and Medicaid certification to maximize use of Medicare funding. MCOs must contract with two HCBS providers in each county across the state for the following HCBS services: • Day supports • Home telehealth (install) • Home telehealth (rental) • Medication reminder (call) • Occupational therapy • Physical therapy • Speech language therapy • Transitional living skills Kansas has set HCBS time and distance requirements for day supports services at 30 miles/60 minutes for urban and semi-urban counties and 60 miles/100 minutes for densely-settled rural, rural, and frontier counties. In addition, the state set timely access standards for HCBS-related services, including: • 21 calendar days for services delivered in-home and services requiring a registered nurse skilled provider • 45 calendar days for self-directed services and services requiring allied health/therapist/other skilled provider • 60 calendar days for high-cost, single unit services, such as assistive technology and services Additionally, the state set standards for the number of days it takes members to receive first service for HCBS, ranging from 21 to 60 calendar days for various services.	
Quality Oversight	Plans must adhere to the requirements of the state's Quality Management Strategy (QMS). The state assesses plans' compliance with the QMS by requiring MCOs to: • Achieve National Committee for Quality Assurance (NCQA) accreditation with LTSS distinction within 24 months of starting operations. • Submit a full set of Healthcare Effectiveness Data and Information Set (HEDIS) and Medicaid Child Core measure sets, as well as experience of care results (i.e., Consumer Assessment of Healthcare Providers and Systems for adult, child, and HCBS populations, National Outcomes Measures, and National Core Indicator (NCI)/NCI- Aging and Disabilities data to the state annually. Plans are also required to submit a variety of reports to various divisions within the state, including on community transitions. Additionally, plans must establish, document, and implement an ongoing comprehensive quality assessment and performance	5.9 (RFP) KanCare 2.0 Quality Management Strategy

	improvement program for services that it provides to members, which at a minimum, must include the following elements: • Performance improvement projects that focus on clinical and nonclinical areas. Each performance improvement project must adopt principles of rapid cycle process improvement and be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. MCOs must report the status and results of each project to the state on an annual basis, or more frequently as requested by the state or EQRO. • MCOs must collect and report performance measurement data, including performance measures relating to quality of life, rebalancing, and community integration activities for members receiving LTSS. • Develop and implement mechanisms to detect both underutilization and overutilization of services. • Develop and implement mechanisms to compare services and supports received with those set forth in the member's treatment/service plan for individuals enrolled in LTSS waivers. • Develop and implement mechanisms to identify members who are enrolled in LTSS waivers but who are not receiving any waiver services. • Develop and implement mechanisms to identify and address behavioral health service needs of members. Plans must ensure the member receives all identified state approved behavioral health services for any unmet service needs. • Develop and implement mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. • Develop and implement mechanisms to assess the quality and appropriateness of care furnished to members receiving LTSS, including assessment of care between care settings. • Participate in efforts by the state to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements for the state for HCBS waiver, behavioral health, and institutional programs. Plans must identify, track and review critical incidents to address potential and actual quality of care and/or health and safety issues. • Report to the state on the results of efforts to support community integration for members using LTSS.	
Telehealth	MCOs must cover certain medically necessary telehealth services, including office visits, individual psychotherapy, and pharmacological management services. Plans are also required to cover speech language pathology and audiology services via telehealth. Telehealth can be used to monitor members in the home setting for significant changes in health status, provide assessment of chronic conditions, and provide other skilled nursing services. HCBS beneficiaries eligible for face-to-face nursing visits provided by a home health agency may receive home telehealth visits with documentation of medical necessity and prior authorization. MCOs must use telehealth to support an adequate provider network, but cannot use telehealth to replace provider choice and/or member preference for physical service delivery. MCOs are required to establish telehealth capabilities in all areas of operation, but especially in rural areas where behavioral health services may be less available.	State Telehealth Laws & Reimbursement Policies, Center for Connected Health Policy, 2019 5.5.2 (RFP) 5.7 (RFP)

	Plans are required to submit proposals for VBP arrangements to the state related to models that expand the use and effectiveness of telehealth strategies (*see VBP Arrangements above for more information*).	
Self-Direction	Individuals on the I/DD waiver may self-direct the following services: • Enhanced care service • Financial management services (FMS) • Overnight respite care • Personal care service MCOs are required to provide the following services for members on the I/DD waiver related to self-direction: • Offer information about self-direction of services and the associated responsibilities by the plan during the service planning process. • Assist members with identifying an FMS provider and related information and ensure that it's included in the member's PCSP. • Support the member who selects self-direction of services by monitoring services, making needed PCSP updates, and providing referrals and follow-ups to relevant supports and services as needed.	Kansas 1115 Waiver Special Terms and Conditions Kansas - HCBS-I/DD Waiver
Additional Information	Members eligible for Working Healthy, the state's Medicaid buy-in program, may receive HCBS through the WORK program.[2] Unlike other HCBS programs in Kansas, WORK is not operated under the 1915 (c) HCBS waiver authority. Instead, WORK is authorized under the Affordable Care Act as an alternative benefit plan—it's a Medicaid state plan package of services targeting individuals enrolled in Working Healthy who demonstrate a need for such services. WORK includes a needs assessment, personal assistance services, independent living counseling, and assistive services. To receive these services, individuals must first be eligible for Working Healthy, and then demonstrate the same need for services as individuals on the I/DD, physical disability, or TBI waiver. WORK utilizes a "cash and counseling" model for the provision of personal assistance services. This model goes a step beyond self-direction, allowing members to manage their funds and purchase personal assistance, providing flexibility in terms of how they purchase their services. MCOs must: • Contract with an FMS organization to administer the WORK monthly allocations for the MCO's members participating in the program and coordinate with the FMS organization to receive monthly allocation reports at the member level.	5.18 RFA 5.19 RFA

[2] To qualify for Working Healthy, an individual must have a disability determined by Social Security, be between the ages of 16 and 64, earn more than $65 per month, have total countable income of less than 300% of the FPL, not be receiving HCBS, not be an SSI recipient, not be living in a nursing facility, and have countable resources that are less than $15,000.

	• Cover the cost of background checks for personal assistance service providers. • Provide service coordination services for members in the WORK program in accordance with the requirements of the Working Healthy program. Service coordinators are responsible for facilitating member understanding and use of WORK program services; accurate assessment of member service needs (to be completed in the member's home within 14 calendar days of referral for the program by the state); ongoing review, approval and monitoring of individualized budgets; and referrals to other resource agencies as needed to address member needs. • Designate an individual on the plan's staff to serve as the state's primary point of contact for all issues related to the WORK program • Maintain an adequate number of qualified and trained service coordinators to serve WORK program participants, and ensure that all newly hired service coordinators serving WORK program participants receive training provided by the state before initiating support for the WORK participants. • Upon monthly notification from the state of all members eligible for the WORK program, assign new members a service coordinator from among the MCO's service coordinators. The state reserves the option to pursue a 1915 (i) state plan amendment or 1915 (i)-like waiver to offer a limited set of services to support independence and employment for individuals with disabilities or behavioral health conditions living and working in the community during the term of the contract. If initiated, the MCO may be required to assess members for eligibility, contract with providers to address the needs of the target population, and provide service coordination services. It is unclear from publicly-available sources whether the state has moved forward with pursuing such authority.	