**ATTACHMENT C**

**Services**

1. **Overview of Services**

1.1 It is the intention of the State to award contracts for provision of services to all eligible populations statewide. The CONTRACTOR(S) shall assume responsibility for all medical conditions of the populations included in KanCare except those medical conditions specifically excluded below in Section 7. The CONTRACTOR(S) shall ensure the provision of medically necessary services, including prescription drugs, as specified below, subject to all terms, conditions, and definitions of the RFP. Covered services shall be available statewide through the CONTRACTOR(S) or their subcontractors.

1.2 The CONTRACTOR(S) shall agree to assume responsibility for all medical, behavioral health, home‑ and community‑based services (HCBS) and long‑term care (LTC) services of each program Member as of the effective date of coverage under this contract. The CONTRACTOR(S) shall ensure the provision of medically necessary services as specified below, subject to all terms, conditions, and definitions of this contract. The CONTRACTOR(S) shall ensure the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The CONTRACTOR(S) shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely for cost savings or because of the diagnosis, type of illness, or condition. The CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and are in compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA). Any and all disputes relating to the definition and presence of medical necessity shall be resolved in favor of the State. Covered services shall be available through the CONTRACTOR(S) or its Subcontractors.

1.3 The CONTRACTOR(S) shall maintain a benefit package and procedural coverage for Members at least as comprehensive as the Medicaid fee‑for‑service (FFS) plan. Experimental surgery and procedures are not covered under the State Medicaid and Children’s Health Insurance Plans (CHIP). CONTRACTOR(S) may cover experimental surgery and procedures but shall not require Members to undergo experimental surgery or procedures. For a complete list of services covered for medical care, behavioral health care, HCBS, and LTC services, please refer to the Kansas Medicaid Provider Manuals located at [https://www.kmap‑state‑ks.us/public/providermanuals.asp.](https://www.kmap-state-ks.us/public/providermanuals.asp.)

1.4 The CONTRACTOR(S) agrees to serve all Members for whom current payment has been made to the CONTRACTOR(S) without regard to disputes about enrollment status.

1. **Medical Services**

The following services and scope of these services as described in the Medicaid Provider Manuals are reflective of current State FFS limitations and must be covered under the terms of this contract. Covered services include but are not limited to the following:

2.1 Inpatient (IP) hospital services based on medical necessity, including but not limited to:

2.1.1 Acute Medical Detoxification providing 24‑hour availability of non‑surgical medical treatment for acute intoxication and/or life threatening conditions, under the direction of a physician in a hospital or other suitably equipped medical setting, with continuous services to persons afflicted with an alcohol and/or drug related crisis. See the KDADS Licensing Standards and Kansas Medical Assistance Program Substance Use Disorder Provider Manual for eligibility and service requirements.

2.1.2 Maternity services.

2.1.3 Outpatient (OP) hospital services.

2.1.4 Inpatient psychiatric services.

2.2 Emergency room services based on the prudent layperson standard for Emergency Medical Conditions (See Attachment A, Definitions and Acronyms).

2.3 Physician services, including primary preventive care and well child check‑ups, as well as specialty physician services.

2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT): The CONTRACTOR(S) must provide EPSDT screenings to all Medicaid Enrollees under 21 years of age and all CHIP under 19 years of age.

2.4.1 EPSDT Background and Definition: The CONTRACTOR(S) shall comply with Federal law and regulations (42 CFR Part § 441 subpart B) governing the administration of the Medicaid services which require that a state provide health screening and necessary diagnostic and treatment services for all children under age 21 who are eligible for Medicaid. EPSDT is sometimes referred to as KAN Be Healthy (KBH) in Kansas. All references and provisions relating to EPSDT coverage shall also include all children enrolled under this contract under the age of 19 who are eligible for CHIP benefits. The federal law requires the State to have, at a minimum, eighty percent (80%) of all Medicaid Enrollees under 21 years of age EPSDT screened. The State recommends the use of the Bright Futures/AAP Periodicity Schedule. The State expects the CONTRACTOR(S) to work with Providers to ensure completeness of all screenings done for each age range. The State is committed to assuring that as many eligible children as possible have a source of regular ongoing health care. A child should be able to receive examination, treatment, and when necessary, referral services from one Provider to another Provider. This program allows enrollees under the age of 21 years (under the age of 19 years for CHIP) to receive any services which are medically necessary (Attachment A, Definitions and Acronyms).

2.4.2 Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

2.4.3 Reporting as specified by Federal regulations and in Attachment H.

2.4.4 The CONTRACTOR(S) must describe planned outreach, monitoring, and evaluation strategies for EPSDT. The CONTRACTOR(S) will describe their Provider education activities that increase beneficiary awareness and access to EPSDT services. The CONTRACTOR(S) will illustrate specific outreach activities designed to increase beneficiary participation in the EPSDT program, and measures which will be used to monitor success.

2.5 Other Preventive Screening including but not limited to:

2.5.1 Health screening such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

2.7 Prescription Drugs:

2.7.1 The CONTRACTOR(S) is required at a minimum to cover medications and supplies consistent with the amount, duration, and scope of coverage by the Medicaid FFS program. The CONTRACTOR(S) must allow Members access to a wide variety of prescribed drugs though a formulary and a preferred drug list (PDL) that is developed by the State, which meets the clinical needs of Members.

2.7.1.1 The PDL must have provisions that will allow access to all non‑preferred drugs that are on the formulary through the structured prior authorization (PA) process used by the FFS program. Specific State laws for mental health prescription drugs also apply. Information about medications and supplies currently covered by Kansas Medicaid is provided below.

2.7.1.2 The CONTRACTOR(S) understands and agrees there will be one PDL under KanCare. The CONTRACTOR(S) may submit criteria for PA for a given drug to the State for consideration for review by the State Mental Health Medication Advisory Committee, the Drug Utilization Review Board, and the Preferred Drug List Committee.

2.7.1.3 The CONTRACTOR(S) is to use the FFS Covered Outpatient Drug (Formulary) file which is loaded weekly to the Secure File Transfer Site by the state Fiscal Agent. The file identifies rebate eligible drugs by National Drug Code (NDC) and includes PDL drug designation. The CONTRACTOR(S) is to use only rebate eligible drugs, unless coverage by the CONTRACTOR(S) is part of a value‑added service and/or otherwise approved by the State. See KanCare guide for additional formulary file information.

2.7.2 Medicaid is required by the Centers for Medicare & Medicaid Services (CMS) to cover all covered outpatient drugs that are rebated by the pharmaceutical manufacturer, in accordance with Section 1927 of the Social Security Act (SSA), with the exception of covered outpatient drugs subject to restriction as outlined in section 1927 (d)(2) of the SSA.

2.7.2.1 The drugs that may be excluded from coverage or otherwise restricted include:

2.7.2.1.1 Agents when used for anorexia, weight loss, or weight gain.

2.7.2.1.2 Agents when used to promote fertility.

2.7.2.1.3 Agents when used for cosmetic purposes or hair growth.

2.7.2.1.4 Agents when used for the symptomatic relief of cough and colds.

2.7.2.1.5 Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations (Vitamins and minerals should be provided where medically necessary for children).

2.7.2.1.6 Non‑prescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A) of the SSA, agents approved by the Food and Drug Administration under the over‑the‑counter (OTC) monograph process for purposes of promoting, and when used to promote, tobacco cessation.

2.7.2.1.7 Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services is purchased exclusively from the manufacturer or its designee.

2.7.2.1.8 Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

2.7.2.2 Kansas Medicaid makes exceptions for some of the agents listed above when determined to be Medically Necessary:

2.7.2.2.1 Prescription weight loss drugs are covered on a restricted basis with PA.

2.7.2.2.2 OTC Product Coverage with a prescription and as defined in current Medicaid State policy.

2.7.2.2.3 Diabetic supplies, including glucometers, lancets, and blood glucose strips are also covered.

2.7.2.2.4 Active pharmaceutical ingredients for compounding. The Active Pharmaceutical Ingredient (API) file is generated by the State fiscal agent and sent to the Secure File Transfer Site for use by the CONTRACTOR(S). See KanCare Guide.

2.7.3 PA: Consistent with all applicable laws the CONTRACTOR(S) is required to use a PA program to ensure the appropriate use of medications and is to be the same criteria as used by the Medicaid FFS program. The CONTRACTOR(S) is to use a Kansas specific customer service representative for PA and pharmacy related issues.

2.7.3.1 In accordance with 42 CFR § 438.3(s)(6) of the CMS Managed Care Rule, the CONTRACTOR(S) is to provide a response to a request for PA for a covered outpatient drug by telephone or other telecommunication device within twenty‑four (24) hours of the request. The clock stops while waiting for documentation and starts when documentation has been received.

2.7.3.2 When medications are needed without delay and PA is not available, a seventy‑two (72) hour emergency supply is to be authorized until a PA can be secured.

2.7.3.3 The CONTRACTOR(S) shall provide appropriate and timely written notice to the requesting Provider and the Member of the authorization and decision to deny a service authorization request in the amount, duration, or scope that is less than the request. The notice must meet the requirements of 42 CFR § 438.404**.** Any applicably licensed pharmacist applying Kansas approved PA criteria to a PA determination is permitted to deny pharmacy‑related PA requests.

2.7.3.4 PA appeals: A general PA appeal is to be responded to within fourteen (14) calendar days of the request and the timeframe may be extended for an additional fourteen (14) calendar days in accordance with 42 CFR § 438.210(d)(1). An expedited appeal is to be responded to within seventy‑two (72) hours of the request and may be extended by fourteen (14) calendar days in accordance with 42 CFR § 438.210(d)(2).

2.7.4 Quantity Limitations: The CONTRACTOR(S) may have in place quantity limitations for covered medications and supplies. These limitations must be based on the maximum recommended dose or supply according to the manufacturer. If there are no published limitations available, the CONTRACTOR(S) may establish reasonable limits based on appropriate use and standards of quality care.

2.7.5 Day Supply Limitation: The CONTRACTOR(S) may establish a day’s supply limitation for Prescription Medications; however, the limitation may not be less than thirty (30) calendar days and does not conflict with the ninety (90) calendar day maintenance drug list (MDL) portion of the current managed care organization (MCO) national average drug acquisition cost (NADAC) policy, or other State day supply limitations.

2.7.6 Early Refill Edit: The CONTRACTOR(S) may also establish an early refill edit for prescription claims. The current early refill edit for Kansas Medicaid FFS claims is 80% (e.g., eighty {80%} of the original prescription must be used prior to a refill being covered for the Member).

2.7.7 Access.

2.7.7.1 The CONTRACTOR(S) must ensure that the pharmacy Provider network is sufficient to provide access to medications and is consistent with the access standards for delivery networks. Network adequacy must meet the time and distance standards determined by the state.

2.7.7.2 The CONTRACTOR(S) is not required to ensure that pharmacies within the Provider network provide home delivery service; however, this is encouraged. The CONTRACTOR(S) must ensure Members have access to medications twenty‑four (24) hours per day, seven (7) days per week. The CONTRACTOR(S) must have in place a process to provide a seventy‑two (72) hour supply of medication to a Member in an emergency situation, on weekends, holidays, or off‑hours.

2.7.7.3 The CONTRACTOR(S) may include mail‑order pharmacies in their networks, but must not require Members to use them. Members who opt to use this service may not be charged fees, including postage and handling fees.

2.7.7.4 The CONTRACTOR(S) must allow pharmacies to fill prescriptions for covered drugs ordered by any licensed Provider regardless of Network participation.

2.7.7.5 Specialty drugs: The CONTRACTOR(S)’ reimbursement formula/rate, and any changes, must be approved by Kansas Department of Health & Environment/ Department of Health Care Finance (KDHE-DHCF). The approved specialty drug reimbursement rate must be offered to all willing Providers and the CONTRACTOR(S) may not require beneficiaries to receive medications through a specific specialty pharmacy program.

2.7.8 Medication Therapy Management (MTM): The CONTRACTOR(S) shall have in place an MTM program with the goal of engaging pharmacists to coordinate drug therapy for patients, and augmenting patient education and self‑management.

i. The CONTRACTOR(S) agrees that beneficiaries with two (2) or more chronic disease states and whose drug therapy includes five (5) or more medications must be deemed to qualify for MTM services. The CONTRACTOR(S) may elect to provide MTM services to beneficiaries with a lower number of disease states or medications, but the CONTRACTOR(S) may not increase the above‑stated minimums.

ii. The CONTRACTOR(S) agrees that MTM services should include, but not be limited to, a review of the following: drug interactions, adverse drug reactions, therapeutic duplication, appropriate drug dosing, active diagnoses and Providers, patient compliance, and patient understanding of drug therapy.

iii. The CONTRACTOR(S) agrees that the listed MTM services must be reviewed both at the patient’s initial MTM encounter and in subsequent Complete Drug Reviews that will occur as needed and on an annual basis.

iv. The CONTRACTOR(S) agrees to standardization between the State and all KanCare Providers of the following credentialing requirements for pharmacists to provide MTM services.

v. The CONTRACTOR(S) agrees that further requirements, standards, criteria, or costs related to credentialing will not be required for pharmacy Providers to provide MTM services beyond the standardized credentialing requirements, to be developed in conjunction with the state and all KanCare Providers as described in iv. above.

vi. The CONTRACTOR(S) agrees that any willing contracted pharmacy Provider who meets the CONTRACTOR(S)’ standardized credentialing requirements will be allowed to provide MTM services.

vii. The CONTRACTOR(S) agrees that reimbursement for MTM services will be a separate component of reimbursement and will not be included in the participating pharmacy’s dispensing fee and/or drug ingredient cost.

viii. The CONTRACTOR(S) agrees that MTM services are to be provided on a face‑to‑face patient/pharmacist basis, and that these services shall be provided by a licensed Kansas pharmacist who is also CONTRACTOR(S) credentialed.

ix. Any other MTM interventions, whether telephonic, electronic, via mail, or by any other means, will only be supplementary to a specific pharmacist/patient face‑to‑face MTM interaction. The CONTRACTOR(S) further agrees the only acceptable manner of beneficiary outreach for MTM services will be via telephonic, electronic, or mail media, for notification of eligibility in the MTM program at a Kansas pharmacy.

2.7.9 Drug Utilization Review (DUR).

2.7.9.1 Prospective DUR: The CONTRACTOR(S) is responsible for ensuring point‑of‑sale pharmacy claims processing and prospective DUR is provided by pharmacies within the pharmacy Provider network. The prospective DUR services include but are not limited to: a review of drug therapy and counseling prior to dispensing of the prescription. The review should include at a minimum a screening to identify potential drug therapy problems including: therapeutic duplication, drug‑disease contraindication, drug‑drug interaction, incorrect dosage, incorrect duration of therapy, drug‑allergy interactions, underutilization (adherence), and over‑utilization or abuse. Coverage of covered outpatient drugs should be appropriate, medically necessary, and not likely to result in adverse medical events. The DUR program must comply with the requirements of section 1927(g) of the SSA as specified in 42 CFR § 438.3(s)(4).

2.7.9.2 Retrospective DUR: The CONTRACTOR(S) is required to collaborate with the State in retrospective DUR and to include an academic detailing component. The CONTRACTOR(S) shall perform physician and pharmacy profiling and education with specific intent to decrease frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care when such patterns have been identified in the retrospective DUR.

2.7.9.3 Pursuant to requirements of 42 CFR § 438.3(s)(5), the CONTRACTOR(S) must provide a detailed description of DUR program activities annually to the State, to include the results of the reviews and educational programs designed to address those results, regarding retrospective DUR.

2.7.9.4 Pursuant to requirements of 42 CFR § 438.3(s)(2) and (3), the CONTRACTOR(S) must provide to the State (via the Medicaid management information system (MMIS) as encounter data) all claims information on drugs administered to Members, if the CONTRACTOR(S) is responsible for coverage of such drugs, no later than forty‑five (45) calendar days after the end of each quarterly rebate period. Utilization data is to be by date of service; not paid date. Adjustments need referenced the same.

2.7.10 Reports.- See Attachment H for pharmacy reports required by the State.

2.7.10.1 Ad hoc reports may be requested by the State for State quarterly pharmacy meetings.

2.7.11 Timely claims payment: See 42 CFR § 447.46 for reference to time requirements for pharmacy claims payment.

2.7.12 Website.

i. Website links to the KDHE Pharmacy page for PA criteria and PA forms is required. Reference to the Kansas Medical Assistance Program (KMAP) NDC/HCPCS look‑up tool is suggested for Provider convenience.

2.7.12.1 See RFP for additional website requirements.

2.7.13 Rebate Processing and Resolution: The CONTRACTOR(S) is to process and resolve rebate claim disputes according to the State’s KanCare Guide.

2.7.14 Reimbursement.

2.7.14.1 The CONTRACTOR(S) agrees to reimburse pharmacy Providers at or above the rate of the State‑mandated pharmacy dispensing fee. The State will provide at least ninety (90) calendar day notice of changes in dispensing fees, which the CONTRACTOR(S) will be required to implement as required in the notice (regardless of the completion date of any formal policy change that the State may utilize to formalize documentation of the change).

2.7.14.2 The CONTRACTOR(S) is required to reflect the actual amount paid to pharmacy Providers on the encounter claims according to the NCPDP Basis of Value codes as requested by the State.

2.7.14.3 For those pharmacy claims for which a Pharmacy MAC structure is appropriate, the CONTRACTOR(S)’ MAC cannot be more strict than the State’s MAC. The CONTRACTOR(S) is required to follow these processes:

i. On or before January 1 of each CONTRACT year, notify contracting pharmacies the basis of the methodology and sources utilized to determine the maximum allowable cost (MAC) pricing of the PBM.

ii. Update MAC pricing information regularly.

iii. Make MAC pricing information available directly or by active link from a central KanCare website.

iv. Establish a process for the timely notification of the MAC pricing updates to network pharmacies.

v. Eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace.

vi. Provide a reasonable administrative appeals procedure to allow a dispensing Provider to contest a listed MAC rate that includes the following:

a. The PBM must respond to a Provider who has contested a MAC rate through this procedure within thirty (30) calendar days.

b. If an update is warranted, the PBM shall make the change retroactive to the date of service and make the adjustment effective for all pharmacy Providers in the network.

2.7.15 340B.

2.7.15.1 The CONTRACTOR(S) must ensure that claims from all 340B Provider types for products purchased through the 340B discount drug program can be identified at the claim level and that this information is included on each encounter.

2.7.15.2 The CONTRACTOR(S) is to work with the State to ensure a procedure is in place to exclude utilization data associated with 340B purchased drugs from the State drug rebate invoicing process.

2.7.15.3 The CONTRACTOR(S) must have included in each network pharmacy Provider agreement, language regarding reimbursement methods for both 340B Carve‑In Medicaid status and Carve‑Out Medicaid status. This is to allow reimbursement for 340B Covered Entity Medicaid status changes to become effective in a timely manner and to limit the need to re‑contract at a later date.

2.8 Home health services including home health aide services and skilled nursing services (free‑standing and hospital‑based) in accordance with 42 CFR § 440.70.

2.9 Medical supplies as ordered by a qualified health plan Provider.

2.10 Durable medical equipment (DME) as ordered by a qualified health plan Provider. The CONTRACTOR may choose to require PA.

2.11 Physical therapy (PT) services when rehabilitative in nature for each injury or acute episode.

2.12 Occupational therapy (OT) services when rehabilitative in nature for each injury or acute episode.

2.13 Speech therapy (ST) services when rehabilitative in nature for each injury or acute episode.

2.14 Audiology and hearing services, including but not limited to:

2.14.1 Hearing aids and repairs.

2.15 Laboratory services meeting Clinical Laboratory Improvement Act (CLIA) Standards, as ordered by a qualified health plan Provider. All lab service Providers must have a CLIA certification on file with the CONTRACTOR(S). The CONTRACTOR(S) shall edit claims based on laboratory tests provided by a laboratory that has the appropriate CLIA certification. Claims shall be paid only if the laboratory is performing tests for their proper CLIA certification for the lab code billed.

2.16 Ambulance services.

2.17 Diagnostic and therapeutic radiology as ordered by a qualified health plan Provider.

2.18 Life sustaining therapies (such as chemotherapy, radiation, inhalation therapy or renal dialysis) as ordered by a qualified health plan Provider.

2.19 Blood transfusions, including autologous transfusions, as ordered by a qualified health plan Provider.

2.20 Mid‑level Practitioners Services.

2.20.1 Advanced Practice Registered Nurse (APRN), including Psychiatric Nurse Practitioner.

2.20.2 Certified Registered Nurse Anesthetists (CRNA).

2.20.3 Nurse Midwives (Federal guidelines permit Members to access this service outside the CONTRACTOR(S)’ plan if the Member desires to receive this service from a nurse midwife; the CONTRACTOR(S) is responsible for payment for this service), and

2.20.4 Physician Assistants.

2.21 Vision Services, including but not limited to:

2.21.1 Eye Exams and glasses including for post cataract surgery.

2.21.2 Contact lenses and replacements.

2.21.3 Artificial eyes.

2.22 Hospice services when ordered by a Participating Provider and a diagnosis of a terminal illness defined as having a prognosis of six months or less if the disease runs its normal course in accordance with 42 CFR § 418.

2.23 Podiatry services for Members under 21 years of age.

2.24 Prenatal Health Promotion/Risk Reduction Enhanced Social Work Services.

2.25 Postpartum/Newborn Home Visit.

2.26 Screening, diagnosis, and treatment of sexually transmitted infections, as medically necessary.

2.27 HIV testing and counseling.

2.28 Dietitian services as medically necessary for members under 21 years of age.

2.29 Chronic Renal Disease (CRD): Treatment services for CRD, also referred to as “End Stage Renal Disease” (ESRD), meaning the stage of renal impairment that appears to be irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life, must be covered by the CONTRACTOR(S) until the Member is eligible for Medicare (Title XVIII) coverage.

2.29.1 CONTRACTOR(S) must maintain on file a copy of the verification from the Social Security Administration stating this Member is not entitled to Medicare, a Medicare denial, and Explanation of Benefits, or a copy of the Medicare card. If a Member did not have self‑dialysis training in the first three months of maintenance dialysis, the encounter data should be accompanied by a Provider’s evaluation of the Member for self‑dialysis training.

2.30 Vaccinations.

2.30.1 Members (ages 0 ‑ 18) in the Title XIX and Title XXI program receive their vaccines from the Vaccines for Children Program. The Advisory Commission on Immunization Practices (ACIP) schedule should be followed. CONTRACTOR(S) should encourage their Providers to become Vaccines for Children Providers.

2.31 Ventilator Services.

i. The purpose of the NF ventilator program is to provide twenty‑four (24) hours a day treatment and care for mechanical ventilator dependent residents. Mechanical ventilation is defined as a life support system designed to replace and/or support normal ventilator lung function. There is currently one NF providing ventilator care in the Kansas Medicaid program. The facility has a licensed bed capacity of forty‑four (44) with twenty‑three (23) unduplicated persons served in the ventilator program in Fiscal Year 2017.

ii. A pulmonologist, or licensed physician experienced in the management of residents requiring ventilator care will direct the plan of care for each resident requiring respiratory therapy services, assess the resident’s status every thirty (30) calendar days with corresponding progress notes, and be available on an emergency basis. Ventilator service Providers enrolled in the Kansas Medicaid program must adhere to all Federal NF regulations, State regulations denoted in section 8.2 and KDADS program requirements including but not limited to 42 CFR § 483.25(k), 42 CFR § 483.70(b), K.A.R. 26‑40‑305, 28‑39‑160, 28‑39‑152 and 129‑10‑18.

2.32 Reproductive Services: The CONTRACTOR(S) is required to provide freedom of choice for family planning and reproductive health services, which may be out of the CONTRACTOR(S)’ network. The CONTRACTOR(S) is responsible for payment of these services.

2.32.1 All medically approved services prescribed by physician/ARNP/nurse midwife and physician’s assistant including diagnosis, treatment, counseling, drug, supply, or device to individuals of childbearing age shall be covered.

2.32.2 For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and must always be reported as family planning services, in accordance with mandated federal regulations 42 CFR § 441.250‑§ 441.259.

2.32.3 Sterilizations shall be provided in accordance with the Federally mandated guidelines and consent form.

2.32.3.1 The approved Sterilization consent form can be found on the KMAP website.

2.32.3.2 The form shall be available in English and Spanish, and the CONTRACTOR(S) shall provide assistance in completing the form when an alternative form of communication is necessary.

2.32.3.3 The CONTRACTOR(S) must assure that the Federal Sterilization Consent form required by CMS in 42.CFR § 441.250 ‑ 441.259 is properly completed as described in the instructions and a copy of the Sterilization Consent form is obtained from the performing Provider before paying the service claim. The CONTRACTOR(S) must maintain a copy of the form in the event of audit. In the event of an audit the CONTRACTOR(S) will provide additional supporting documentation to ascertain compliance with Federal and State regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders.

2.32.3.4 Hysterectomies are covered when the requirements, stated in the State Provider Manuals, State Policy and 42 CFR § 441.250‑§ 441.259, are met.

2.33 Abortions are only covered in the instances that:

2.33.1 The pregnancy is the result of an act of rape or incest.

2.33.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life‑endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a physician, place the woman in danger of death unless an abortion is performed.

2.34 LTC Services.

2.34.1 Nursing Facility (NF) Services

2.34.2 HCBS

2.34.3 Head Injury (HI) Rehabilitation Services.

2.34.4 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF‑IID)

2.35 Dental services for those populations currently eligible to receive them.

2.36 Non‑emergency medical transportation (NEMT) to medically necessary services listed in State Policy and State Provider manuals, in compliance with all Federal regulations, including but not limited to:

2.36.1 Mileage reimbursement to medically necessary services.

2.36.2 Lodging and meals for the member and one attendant when the receipt of medical services necessitates an overnight stay.

2.36.3 Transportation to family planning services even if these services are obtained from a Provider not participating in the CONTRACTOR(S)’ network.

2.37 All waiver‑funded services listed in this Section 5.0 of this attachment.

2.38 In addition, medically necessary services shall include services as defined elsewhere in the RFP, including services to treat mental illness, SUD, HCBS, and LTC.

2.39 Bariatric Surgery.

2.40 Transplant Services.

2.41 Telemedicine

1. **SUD Services**

The CONTRACTOR(S) must provide at least as much access to Medically Necessary substance use disorder treatment services for Members as was provided under the current delivery system or as directed by any changes to the State plan or policy. The CONTRACTOR(S) shall use Kansas definition of medical necessity and the American Society of Addiction Medicine (ASAM) criteria as contained in the State Approved Assessment Tool when determining the need for SUD services. These criteria are no more restrictive than those of the State Title XIX program. The CONTRACTOR(S) may not set limits on the amount, scope, or duration of these services for Members that were not imposed in the previous delivery program. The CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria such as the Kansas definition of medical necessity, ASAM criteria as contained in the State Approved Assessment Tool, and best practice guidelines, provided that the services furnished can reasonably be expected to achieve their purpose.

3.1 Court Referred Treatment:

i. The CONTRACTOR(S) shall work with the Provider network for placement for medically necessary, court‑ordered or court‑referred treatment of covered services of Members. The CONTRACTOR(S) shall work with the courts to examine the appropriateness of court‑ordered placements while examining the potential of offering more efficient alternatives and shall develop specific alternatives for the courts to consider which shall be based on the Kansas definition of medical necessity and ASAM criteria as contained in the State Approved Assessment Tool.

3.2 Civil Commitments.

i. Involuntary Commitments: The CONTRACTOR(S) shall work with State approved Providers for placement for medically necessary, civil commitments of covered services for Members as cited in K.S.A 8-1567.

3.3 Please see the Kansas Medical Assistance Program Substance Use Disorder Provider Manual for covered SUD services.

3.3.1 Description of Services.

3.3.2 General Principles.

3.3.2.1 For all modalities of care, the duration of treatment should be determined by the Member’s needs and his or her response to treatment.

3.3.2.3 More details on all modalities of care are available in the Licensing Standards for Kansas.

3.3.2.4 The CONTRACTOR(S) shall provide assurance that any Providers delivering services are licensed as required by applicable State laws. Currently State law also requires that any Provider of SUD treatment services in a facility setting be licensed by KDADS/BHS to provide SUD treatment services; that any Provider determining the medical necessity of such services according to the Kansas definition must be a Behavioral Sciences Regulatory Board (BSRB)‑licensed practitioner practicing within their scope as defined by the BSRB.

3.3.3 Level I: Outpatient and Level II: Intensive Outpatient Treatment/Partial:

i. Outpatient and Intensive Outpatient treatment consisting of non‑residential treatment consisting of group, individual, and/or family counseling. See the Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual for eligibility and service requirements.

3.3.4 Level III: Community‑based Residential Treatment:

3.3.4.1 “3.1 Reintegration and 3.3/3.5 Intermediate Treatment”

i. Reintegration and Intermediate treatment provide a regimen of structured services in a twenty‑four (24) hour staffed (awake on all shifts) residential setting. See the Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual for eligibility and service requirements.

3.3.4.2 “3.7 D Acute Community‑based Detoxification Treatment”

i. Acute detoxification treatment provides care to those individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services in a residential setting. In this modality of treatment, twenty‑four (24) hour observation, monitoring and counseling services are available. See the Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual for eligibility and service requirements.

3.3.5 Auxiliary Services.

3.3.5.1 Substance Use Assessment and Referral:

i. Substance Use assessment and referral programs provide ongoing assessment and referral services for individuals presenting a current or past abuse pattern of alcohol or other drug use. The assessment is designed to gather and analyze information regarding a Member's current substance use behavior and social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, behavioral health related treatment or referral. The State approved assessment tool shall be used by SUD Providers.

3.3.5.2 Case Management:

i. Case Management Services assist Members to become more self‑sufficient through an array of services which assess, plan, implement, coordinate, monitor, and evaluate the options and services to meet a Member’s needs, using communication and available resources to promote quality, cost effective outcomes. Case management services are provided in OP levels of care or as indicated by the State plan.

3.3.5.3 Peer Support:

i. Peer mentoring (support) is provided by people who are in long‑term recovery and have been trained in providing recovery support. The purpose of providing this service is to help build recovery capacity for persons new to recovery by connecting them to naturally occurring resources in the community, assist in reduction of barriers to fully engaging in recovery, and providing support in skill development for maintaining a recovery life style.

3.4 The CONTRACTOR(S) must develop a network of Providers, which is supported by written contracts, to ensure availability of the services listed above for both adults and youth. A full continuum of SUD services must be available statewide in accordance with accessibility standards in the RFP and resultant CONTRACT.

1. **Mental Health (MH) Services**

The CONTRACTOR(S) will provide all medically necessary services to Members accessing care through the MH service system or as directed by any changes to the State plan or policy. All services will be provided in accordance with service definitions and operational limits as approved by the State. All service provided shall be practice‑research based or evidence‑based and consistent with fidelity to a model. Examples in rehabilitation services include; Supported Employment, Integrated Dual Diagnosis Treatment, Strengths‑based Community Psychiatric Support and Treatment (CPST), and Family Psycho‑education. Outpatient examples include Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Positive Behavior Supports, and Shared Decision Making. The CONTRACTOR(S) will maintain current sites where these practices are already available and will add at least two new sites annually until these services are available statewide. Particular attention will be paid to evidence‑based practices which are proven to reduce the need for hospitalization. Covered MH services include all services listed below, but are not limited to these services.

4.1 Initial Admission Evaluation and Assessment.

4.2 Outpatient Therapy services.

4.3 Medication Management and pharmacology services.

4.3.1 Medication‑Assisted Treatment (MAT):

4.3.1.1 MAT combines the use of medications with counseling and behavioral therapies to treat substance use disorders such as alcohol use and opioid use disorders.

4.3.1.1.1 Opiate Abuse:

i. Kansas is ranked 16th in the United States for opioid prescribing rates. KDHE reports that between 2013 and 2015, Kansas’ prescription opioid overdose death rate increased by twenty‑eight (28%) and heroin deaths increased by seventy‑one (71%). In 2015 in Kansas, nine (9) out of ten (10) poisonings were due to prescription drugs, illicit drugs, and OTC medications. Pharmaceutical opioids remain the leading cause of drug poisoning deaths in Kansas.

ii. There are currently nine (9) methadone treatment clinics in five (5) counties in Kansas that provide non‑residential services that support the concept of long‑term methadone maintenance or other medication assistance to prevent return to opiate abuse. While the ideal goal is to achieve drug‑free status, abstinence is not viewed as a primary goal of methadone/medication assistance maintenance, but is a goal that is achieved by some clients.

4.3.1.1.2 SUD Treatment and MAT

i. The CONTRACTOR(S) shall ensure coordination of care for individuals with opioid use, alcohol dependence and other SUDs to include the provision of traditional treatment services concurrent with medication assisted treatment when medically indicated. The CONTRACTOR(S) shall improve and expand the network of MAT Providers for opioid use and other substance use disorders. The CONTRACTOR(S) shall educate enrollees and Providers on the prevention and treatment of opioid use, alcohol use and other SUD evidence‑based MAT practices.

4.4 Rehabilitation services for those individuals that meet the functional assessment criteria for the target population as described in Section 4.5.

4.4.1 Community Psychiatric Support and Treatment (CPST).

4.4.2 Psychosocial Rehabilitation.

4.4.3 Peer Support.

4.4.4 Basic Crisis Intervention.

4.4.5 Intermediate Crisis Intervention.

4.4.6 Advanced Crisis Intervention.

4.5 Assessment qualifications for the target population as defined through the Severely Persistently Mental Health (SPMI) Risk Assessment can be found: [http://www.kdads.ks.gov/docs/default‑source/SCC‑Documents/Health‑Occupations‑Credentialing/severe‑and‑persistent‑mental‑illness‑definition.pdf](http://www.kdads.ks.gov/docs/default-source/SCC-Documents/Health-Occupations-Credentialing/severe-and-persistent-mental-illness-definition.pdf)

4.6 Services and supports in a frequency, support, and duration that supports and maintains the individual’s opportunity to remain in their home and community.

4.7 Targeted Case Management (TCM).

4.8 Screening and Assessment for risk of inpatient care.

4.9 Treatment Planning that includes the consumer/Member/family’s involvement in the development of goals, interventions, and scope of service.

4.10 Crisis Response and Intervention Services that ameliorate the risk for harm to self or others when the Member self identifies.

4.11 Personal Care Attendant.

4.12 Case Conference

4.13 Early Childhood Mental Health Assessment Services.

4.14 Psychological Testing/Assessment.

4.15 Inpatient Psychiatric Treatment.

4.16 PRTFs:

i. PRTF services must provide active treatment in a structured therapeutic environment for children and youth with significant functional impairments resulting from an identified mental health diagnosis, SUD diagnosis, or an MH diagnosis with a co‑occurring disorder (for example, substance‑related disorders, intellectual/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues.) Such services are provided in consideration of a child’s developmental stage.

4.16.1 PRTF Criteria:

i. Providers must provide services in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary’s discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 CFR. § 441.154 through § 441.156.

1. **HCBS**

HCBS Waivers are Medicaid programs designed to provide services to a person in their community instead of an institution, such as a nursing home or state hospital. Presently, there are seven (7) 1915(c) waivers in Kansas which serve different target populations and, at the same time, are administered concurrently with the 1115 Demonstration Waiver known as KanCare. In Kansas, the KDHE acts as the Single State Medicaid Agency while Kansas Department for Aging and Disability Services (KDADS) serves as the operating agency for HCBS programs. All HCBS services are to be delivered in compliance with the then‑current, approved waiver or other CMS‑approved requirements and applicable State policies. Detailed information about the HCBS waivers in Kansas can be found at: [http://www.kdads.ks.gov/commissions/home‑community‑based‑services‑(hcbs)](http://www.kdads.ks.gov/commissions/homecommunitybasedservices(hcbs)). All HCBS services are to be delivered in compliance with the then‑current, approved waiver or other CMS‑approved requirements and applicable State policies.

A copy of each entire approved waiver can be found on the KDADS website:

[https://www.kdads.ks.gov/commissions/home‑community‑based‑services‑(hcbs)/hcbs‑program‑renewal‑information](https://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs)/hcbs-program-renewal-information)

HCBS codes can be found on the KMAP website:

[https://www.kmap‑state‑ks.us/Public/Provider.asp](https://www.kmap-state-ks.us/Public/Provider.asp)

A copy of the FMS Provider manual can be found on the KMAP website:

[https://www.kmap‑state‑ks.us/Documents/Content/Provider%20Manuals/HCBS\_FMS\_02022017\_17009.pdf](https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/HCBS_FMS_02022017_17009.pdf)

5.1 Intellectual/Developmentally Disabled Waiver Services.

5.2 Physically Disabled Waiver Services.

5.3 Technology Assisted Waiver Services.

5.4 Autism Waiver Services.

5.5 TBI Waiver Services.

5.6 Frail and Elderly (FE) Waiver Services.

5.7 Serious Emotional Disturbance (SED) Waiver.

1. **Institutional Transitions**

6.1 Participants in Nursing Facilities, Nursing Facilities for Mental Health, Mental Health State Hospitals (Larned and Osawatomie), IID State Hospital (Parsons and Kansas Neurological Institute (KNI)), private ICF‑IIDs, or PRTFs, with current Medicaid eligibility, and meet eligibility for services on the corresponding HCBS waiver shall transition from the institutional settings into the community if it is their choice and if the services required to meet their individual needs are available in the community. The populations served are persons eligible for the [Intellectual/Developmental Disability](http://www.kdads.ks.gov/provider-home/home-and-community-based-services-provider-information/intellectual-developmental-disability-provider-information) (I/DD) waiver, Physical Disability (PD) Waiver, TBI waiver, SED, or FE Waiver. In addition to the existing waiver services, the MCOs may utilize the “in lieu of” process within the 1115 Waiver to provide any service needed for a successful transition. Below are examples of transition services that may be utilized. The intent is to assure that the barriers to a successful transition are addressed with these additional services and the flexible benefits they can offer.

6.1.2 Institutional Transition “In Lieu of” services may include:

6.1.2.1 Transition services (immediate start‑up costs) include direct costs incurred by the individual related to their ability to access community residential housing. Such costs include housing and utility deposits (rent/lease/purchase costs not allowed), the purchase of basic furnishing, linens, cooking and eating equipment/utensils, and other basic living costs that are necessary.

6.1.2.2 Transition Coordination Service includes an individual (from the MCO) who works with the resident in pre‑transition planning to evaluate suitability for a transition into the community. The resident’s hopes and dreams will be identified and the transition coordinator will assist the resident in realizing their goal of moving into a community based setting. Transition Coordination activities include: helping the consumer to identify and eliminate potential barriers that would prohibit transitioning to the community, facilitating and developing natural support systems, and providing information to concerned family and friends upon the consumer’s request/release of information.

6.1.2.3 Assistive Services (existing waiver service but Transition specific benefits) include direct costs for adaptive equipment/technology and home modifications that are necessary to ensure successful community living and which are in addition to HCBS Waiver home modification or exceed HCBS Waiver limitations.

6.1.2.4 Immediate Access to services:

i. Individuals meeting waiver eligibility criteria shall be allowed to transition directly onto the appropriate HCBS waiver. In the event the HCBS waiver has a waiting list, the individual shall be allowed to bypass the waiting list and immediately access waiver services if meeting requirements as directed by State policy.

6.1.3 In order to access HCBS waiver services, the individual must meet the eligibility criteria established in each CMS approved HCBS waiver as well as Medicaid financial eligibility. If Medicaid financial eligibility is not met, the individual will be assessed to determine eligibility for services available under the Older American Act and/or Kansas’ State Plan services.

1. **Services Not Included**

The following services are not covered under this contract unless otherwise indicated, but may be covered under FFS in Title XIX eligible persons.

7.1 Any activities/services in violation of the Assisted Suicide Funding Restriction Act of 1997.

7.2 State Institution Services:

i. State hospitals for people with intellectual or developmental disabilities that are also public ICFs/IID.

7.3 School‑based Services, Early Intervention Services ordered through an Individual Education Plan (IEP) or Independent Family Services Plan (IFSP) Local Education Agencies (LEAs), Head Start Facilities, Part C of the Individuals with Disabilities Education (IDEA) Act.

7.4 Laboratory services performed by the KDHE.

1. **Other Activities to be Addressed**

In addition to and consistent with those activities identified in the RFP and this Attachment, the CONTRACTOR(S) will be required to specifically address the following activities.

8.1 During the term of the contract, the CONTRACTOR(S) shall propose for review and State approval special new treatment services and programs for Members for which the CONTRACTOR(S) may need to adapt its Provider network. Self-direction, Evidence-Based Practices (EBP), employment, and housing, ensure the CONTRACTOR(S) knows this is an expectation.

8.2 The CONTRACTOR(S) shall perform a cost‑benefit analysis for any new service it proposes to develop, as directed by the State, including how the proposed service will not have an impact on the Title XIX capitation rates or on the non‑Title XIX payments. The CONTRACTOR(S) shall implement those new special services and programs approved by the state and CMS (as necessary).