ATTACHMENT F
Amended 12/09/2011
Services

1.0 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 listed in Section 1.3.6 except those medical conditions specifically excluded below. 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 shall agree to assume responsibility for all medical, behavioral health, HCBS and LTC services of each program Member as of the effective date of coverage under this contract. The CONTRACTOR shall ensure the provision of medically necessary services as specified below, subject to all terms, conditions and definitions of this contract. The CONTRACTOR shall ensure that 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 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 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. 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 or its subcontractors.

1.3
The CONTRACTOR 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 long-term care services, please refer to the Kansas Medicaid Provider Manuals located at https://www.kmap-state-ks.us/public/providermanuals.asp.

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

2.0 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:
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. In addition to having a physician's direction, one registered nurse or one licensed practical nurse must be on duty 24 hours per day for every 10 patients.
2.1.2
Maternity services: coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both mother and newborn child.
2.1.3
Outpatient (OP) hospital services, based on medical necessity
2.1.4
Inpatient psychiatric services except as specified in section 6.3 below

2.2
Emergency room services based on the prudent layperson standard (See Attachment C, Definitions and Acronyms)

2.3
Physician services, including primary preventive care and well child check-ups, as well as specialty physician services such as Screening Brief Intervention and Referral to Treatment (SBIRT)

2.4
Inpatient and outpatient mental health and substance use disorder (SUD) services

2.5
Prescription Drugs
2.5.1
The CONTRACTOR(S) is required at a minimum to cover medications and supplies to the extent they are covered 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. The PDL must have provisions that will allow access to all non-preferred drugs that are on the formulary through a structured prior authorization process. Specific state laws for mental health prescription drugs also apply. Information about medications and supplies currently covered by Kansas Medicaid is provided below.
2.5.2
Medicaid is required by CMS to cover all medications which are rebated by the pharmaceutical manufacturer, in accordance with Section 1927 of the Social Security Act, with the exception of drugs subject to restriction as outlined in Sect. 1927 (d)(2) of the Act.
The drugs which may be excluded from coverage or otherwise restricted include:
2.5.2.1
Agents when used for anorexia, weight loss, or weight gain;
2.5.2.2
Agents when used to promote fertility;
2.5.2.3
Agents when used for cosmetic purposes or hair growth;
2.5.2.4
Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations (Vitamins and minerals should be provided where medically necessary for children);
2.5.2.5
Nonprescription drugs;
2.5.2.6
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; and
2.5.2.7
Barbiturates
2.5.3
Kansas Medicaid makes exceptions for some of the agents listed above when determined to be medically necessary. Prescription weight loss drugs are covered on a restricted basis with prior authorization (PA). Smoking cessation products are covered for a maximum of twelve weeks of therapy per year. Benzodiazepines are covered with some restrictions.
2.5.4
Over-the-counter (OTC) Product Coverage with a Prescription
2.5.4.1
OTC products will be covered as defined in current Medicaid State policy.
2.5.4.2
Diabetic supplies, including glucometers, lancets and blood glucose strips are also covered.
2.5.5
Prior Authorization: Consistent with all applicable laws the CONTRACTOR is required to use a prior authorization (PA) program to ensure the appropriate use of medications as specified in section 2.2.14.7 of this RFP.
2.5.6
Quantity Limitations: The CONTRACTOR 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 may establish reasonable limits based on appropriate use and standards of quality care.

2.5.7
Day Supply Limitation: The CONTRACTOR(S) may establish a days supply limitation for prescription medications, however the limitation may not be less than 30 days. 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., 80% of the original prescription must be used prior to a refill being covered for the Member.)
2.5.8
Access: The CONTRACTOR(S) must ensure that the pharmacy provider network is sufficient to provide access to medications and complies with Section 2.2.8 of the RFP. The CONTRACTOR is not required to ensure that pharmacies within the provider network provide home delivery service, however, this is encouraged. The CONTRACTOR must ensure that Members have access to medications 24 hours per day, 7 days per week. The CONTRACTOR(S) must have in place a process to provide a 72-hour supply of medication to a Member in an emergency situation, on weekends, holidays or off-hours.
2.5.8.1
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.
2.5.8.2
The CONTRACTOR(S) must allow pharmacies to fill prescriptions for covered drugs ordered by any licensed provider regardless of Network participation.
2.5.9
Medication Therapy Management (MTM): The CONTRACTOR 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.
2.5.10
Drug Utilization Review: The CONTRACTOR(S) is responsible for ensuring that point-of-sale pharmacy claims processing and prospective drug utilization review (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, and over-utilization or abuse.
2.5.11
Retrospective Drug Utilization Review: The CONTRACTOR(S) is responsible to collaborate with the State in retrospective drug utilization review (DUR) that includes an academic detailing component.
2.5.12
Reports: The CONTRACTOR(S) is required to provide the State with quarterly usage reports. These reports must be stratified by T-XIX, T-XXI, and Children with Special Health Care Needs, Aged, Disabled, Families and Pregnant Women.
The reports required are:
2.5.12.1
Ranking report of drugs by volume of Rxs paid, in descending order
2.5.12.2
Ranking report of drugs by dollars paid, in descending order.
2.5.12.3
At a minimum, the reports must include: generic drug name, strength, dosage form, generic code number (GCN), number of prescriptions paid, dollars paid, number of Members who received the prescription and paid amount per claim and/or average paid amount per claim.

2.6
The CONTRACTOR(S) shall perform physician profiling and education on specific medications as requested by the State.

2.7
Home health services including home health aide services and skilled nursing services (free-standing and hospital-based). CONTRACTOR shall contract only with those Home Health Agencies (HHA) or home health organizations having posted the appropriate required surety bond.

2.8
Physical therapy (PT) services when restorative for each injury or acute episode. Under this contract, the CONTRACTOR must provide a minimum of six months of this service from the date of the first therapy, if medically necessary.

2.9

Occupational therapy (OT) services when restorative for each injury or acute episode. Under this contract, the CONTRACTOR must provide a minimum of six months of this service from the date of the first therapy, if medically necessary.

2.10
Speech therapy (ST) services when restorative for each injury or acute episode. Under this contract, the CONTRACTOR must provide a minimum of six months of this service from the date of the first therapy, if medically necessary.

2.11
Audiology and hearing services
2.11.1
Hearing aids are covered every four (4) years, as ordered by a qualified health plan provider. Lost, broken or destroyed hearing aids will be replaced one time during a four year period provided the documentation of the circumstances adequately supports the need and prior authorization is obtained.
2.11.2
Provision of a binaural hearing aid requires specific documentation of medical necessity supporting significant bilateral loss of hearing.
2.11.3
Hearing aid repairs are covered.
2.11.4
Trial rental of a hearing aid is limited to one month's duration
2.11.4
Provision of hearing aid batteries is limited to six per month for monaural hearing aids and twelve per month for binaural hearing aids.

2.12
KAN Be Healthy screenings, provided to all Medicaid children through the age of 21, and CHIP Members up to age 19 years in accordance with the provisions of 42 CFR 441.58.

2.13
Laboratory services meeting Clinical Laboratory Improvement Act Standards (CLIA), as ordered by a qualified health plan provider. All lab service providers must have a CLIA certification on file with the CONTRACTOR. 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.

2.14
Ambulance services

2.15
Medical supplies as ordered by a qualified health plan provider.

2.16
Durable medical equipment (DME) as ordered by a qualified health plan provider. The CONTRACTOR may choose to require prior authorization or quantity limits for these 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 Registered Nurse Practitioners (ARNP),
2.20.2
Nurse Anesthetists,
2.20.3
Nurse Midwives (Federal guidelines permit Members to access this service outside the CONTRACTOR Plan if the Member desires to receive this service from a nurse midwife; the CONTRACTOR is responsible for payment for this service), and
2.20.4
Physician Assistants (PA).

2.21
Vision Services
2.21.1
One complete eye exam and one pair of glasses are covered for Members 21 years of age and older, every year. Repairs shall be provided as needed.
2.21.2
Eyeglasses, repairs and exams as needed for Members under 21 years of age.
2.21.3
Eye exams, as needed, for post-cataract surgery patients up to one year following the surgery and eyeglasses for post-cataract surgery Members when provided within one year following surgery.
2.21.4
Contact lenses and replacements are covered with prior approval, when ordered by a qualified health plan provider and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses
2.21.5
Artificial eyes are covered.

2.22
Hospice services when ordered by a qualified health plan 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

2.23
Podiatric services; up to two office visits per calendar year

2.24
Prenatal health promotion and risk reduction (risk assessment, counseling, instruction in prenatal care practices, including methods to control risk factors, instruction in effective parenting practices, referral to other support, if needed, and follow-up), as medically necessary

2.25
Newborn Services - One home visit per Member within twenty-eight (28) days after the birth date of the newborn. Also, home visits for the newborn, including risk assessment of the newborn, instruction in parenting practices, additional home visits for the newborn and referral to other support services, if needed.

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

2.27
Dietary services as medically necessary

2.28
HIV testing and counseling

2.29
Chronic Renal Disease: Treatment services for chronic renal disease (CRD), also referred to as “endstage 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 until the Member is eligible for Medicare (Title XVIII) coverage.
2.29.1

CONTRACTOR must maintain on file a copy of the verification from the Social Security Administration (SSA) stating that 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 T-XIX and T-XXI program receive their vaccines from the Vaccines for Children Program. The Advisory Commission on Immunization Practices (ACIP) schedule should be followed. See Attachment E. CONTRACTOR(S) should encourage their providers to become Vaccines for Children Providers.
2.30.2
The following vaccinations are covered for adults:
2.30.2.1
Hepatitis A
2.30.2.2
Hepatitis B
2.30.2.3
Hepatitis A and Hepatitis B
2.30.2.4
Influenza virus (IM)
2.30.2.5
Influenza virus (nasal)
2.30.2.6
Tetanus
2.30.2.7
MMR
2.30.2.8
Tetanus and diphtheria
2.30.2.9
Varicella Virus
2.30.2.10
Tdap
2.30.2.11
pneumococcal vaccine

2.31
Sterilizations shall be provided in accordance with the Federally mandated guidelines and consent form.

2.32
Members shall have freedom of services for family planning as described in Section 2.2.36 of the RFP.

2.33
Long Term Care (LTC) Services
2.33.1
Nursing Facility (NF) Services (see section 8.2 of this ATTACHMENT)
2.33.2
Home and Community Based Services (HCBS)
2.33.3
Head Injury (HI) Rehabilitation Services.
2.33.4
Intermediate Care Facilities for Mental Retardation (ICFMR)

2.34
Dental services for those populations currently eligible to receive them

2.35
Non-emergency medical transportation (NEMT) as specified in Section 2.2.20 and in compliance with all Federal regulations

2.36
All waiver-funded services as described in this ATTACHMENT.

2.37
In addition, medically necessary services shall include services as defined elsewhere in the RFP, including services to treat mental illness, substance use disorders, HCBS, and LTC.

2.38
Bariatric Surgery- This service is not currently covered by the Medicaid program. Each CONTRACTOR shall propose a plan and criteria for covering this service for qualified Medicaid beneficiaries.

3.0 Substance Use Disorder Services

The CONTRACTOR 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. The CONTRACTOR shall use Kansas definition of medical necessity and the American Society of Addiction Medicine (ASAM) criteria as contained in the Kansas Client Placement Criteria (KCPC) system when determining the need for substance use disorder services. These criteria are no more restrictive than those of the State T-XIX program. The CONTRACTOR may not sets limits on the amount, scope or duration of these services for Members that were not imposed in the previous delivery program, as reflected in the Prepaid Inpatient Health Plan (PIHP) contract. If requested, the CONTRACTOR shall offer a second opinion from a qualified health care professional within the network or arrange for a second opinion outside the network at no cost to the Member. The CONTRACTOR 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 KCPC system, and best practice guidelines, provided that the services furnished can reasonably be expected to achieve their purpose.

3.1
Criminal Court Referrals
3.1.1
The CONTRACTOR shall work with the provider network for placement for medically necessary, court-ordered or court-referred treatment of covered services of Members. A significant number of persons seeking substance abuse services enter treatment due to court orders, probation and parole violations, criminal charges or convictions. Criminal justice clients include all non-incarcerated, eligible pre-trail and post-trial populations. The Department of Corrections and the community-based provider network have highly interdependent relationships. In order for treatment to be successful with the corrections population, programs shall provide structure, comprehensive levels of care, and understand the dynamics of working with a highly resistant population.
3.1.2
The CONTRACTOR 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 KCPC system.
3.1.3
The CONTRACTOR has the right to establish policies that require providers of court ordered substance abuse services to provide notification and documentation of court-ordered treatment.

3.2
Civil Commitments
Involuntary Commitments: The Contractor shall work with the Regional Alcohol and Drug Assessment Centers (RADAC) and providers for placement for medically necessary, civil commitments of covered services for Members as cited in K.S.A 59-26b61.

3.3
The following table identifies additional covered SUD services.

T-XIX Funded Services for T-XIX Members		
Service	State Plan	Waiver

Level I - Outpatient		
Individual Counseling	X	
Group Counseling	X	
Level II - Intensive Outpatient Treatment/Partial Hospitalization		
Intensive Outpatient	X	
Level III - Residential/Inpatient Treatment		
3.1 Reintegration		X
3.5 Intermediate		X
3.7D - Acute detoxification		X
Auxiliary Services		
Assessment/Referral	X	
Medicaid Case Management	X	
Peer Support	X	
Crisis Intervention	X	

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.
3.3.2.2
All level I and auxiliary services may be provided via telemedicine
3.3.2.3
A licensee providing residential treatment shall ensure access to consultation with a licensed physician and provide meals that comply with the dietary standards set forth in Addiction and Prevention Services (AAPS) Licensing Standards.
3.3.2.4
More details on all modalities of care are available in the Licensing Standards for Kansas.
3.3.2.5
Licensed Clinical Addictions Counselors (LCAC) may provide OP services as individual practitioners
3.3.2.6
Licensed Addictions Counselors (LAC) must practice inside of an AAPS licensed treatment facility
3.3.2.7
Medication-Assisted Treatment (MAT)
3.3.2.7.1
Opiate Abuse: There are currently seven methadone clinics in Kansas (located in the two largest urban areas of the State), 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. The Contractor shall ensure coordination of care for opiate-dependent individuals to include the provision of traditional treatment services concurrent with medication assisted treatment when medically indicated.
3.3.2.7.2
Other Medication-Assisted Treatment services: The contractor shall encourage the use of all evidenced based MAT treatment practices.

3.3.3
Level I: Outpatient
Outpatient is nonresidential treatment consisting of group, individual, and/or family counseling. For a client who is age 18 years or older, 8 hours or less of scheduled counseling services are provided each week, or for a client who is under age 18 years**,** 5 hours or less of scheduled counseling services are provided each week.

3.3.4
Level II: Intensive Outpatient Treatment/Partial Hospitalization
Intensive outpatient treatment consists of group, individual, and/or family counseling and for a client who is age 18 years or older, a minimum of 9 hours of scheduled counseling services are provided each week, or for a client who is under age 18 years, a minimum of 6 hours of scheduled, counseling services are provided each week.

3.3.5
Level III: Community-based Residential Treatment
3.3.5.1
“3.1 Reintegration”
Reintegration treatment provides a regimen of structured services in a 24-hour staffed (awake on all shifts) residential setting. They are housed in or affiliated with permanent facilities where individuals can reside safely. A minimum of one qualified staff for every fifteen clients in residence shall be assigned. Reintegration shall consist of at least 10 hours of scheduled, structured activities each week to include a minimum of 3 hours per week of individual, group, and/or family counseling provided by approved staff.
3.3.5.2
“3.3/3.5 Intermediate Treatment”
Intermediate treatment provides a regimen of structured services in a 24-hour staffed (awake on all shifts) residential setting. They are housed in or affiliated with permanent facilities where individuals can reside safely. A minimum of one qualified staff for every eight clients in residence shall be assigned. Intermediate treatment shall consist of at least 40 hours each week of scheduled, structured activities to include: a minimum of 10 hours per week of individual, group, and/or family counseling provided by an approved staff.
3.3.5.3
“3.7 D – Acute Community-based Detoxification Treatment”
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, 24-hour observation, monitoring and counseling services are available.
3.3.5.3.1
A licensee providing acute detoxification treatment shall have a registered nurse or licensed practical nurse on duty 24 hours a day on the unit.
3.3.5.3.2
The CONTRACTOR shall ensure 24 hour evaluation and withdrawal management performed by medical professionals in a licensed health care or behavioral health treatment facility, provide services based on policies and procedures that have been approved by the physician, complete a comprehensive medical assessment and physical examination for each detoxification client at the time of admission and maintain access to laboratory and toxicology testing.

3.3.6
Auxiliary Services
3.3.6.1
Alcohol and Drug Assessment and Referral
Alcohol and drug 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 client'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 KCPC shall be used by SUD providers. A licensee shall develop, implement, and comply with policies and procedures that establish processes for referrals for a client. A licensee may conduct an initial screen of an individual's presenting behavioral health problem before conducting an assessment of the individual. A licensee shall comply with Licensing Standards in regard to assessment practices. Once an individual receives an assessment, a staff member shall provide the individual with a recommendation for further assessment or treatment and an explanation of that recommendation.
3.3.6.2
Case Management
Case Management Services assist individuals to become more self-sufficient through an array of services which assess, plan, implement, coordinate, monitor and evaluate the options and services to meet an individual’s needs, using communication and available resources to promote quality, cost effective outcomes. Case management services are provided in OP levels of care.
3.3.6.3

Peer Support
Peer mentoring (support) is an OP service 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.
3.3.6.4
Crisis Intervention
Services can be provided to individuals being served in outpatient and intensive outpatient services in their facility. Facilities providing those services must be client accessible on a 24/7 basis with AAPS credentialed counselors trained in crisis management /intervention skills. Timely response is essential in providing crisis intervention services. Services would follow the established principles of crisis management: 1) providing reassurance and support; (2) evaluating the nature of the problem and determining the patient's mental, psychiatric, suicidal or homicidal, and medical statuses; (3) ensuring the safety of the patient and others; (4) assisting the patient in developing an action plan that minimizes distress, and obtaining patient commitment to the plan; and (5) following up with the patient and other relevant persons to ensure follow-through, assess progress, and provide additional assistance and support. Medication or referral for psychiatric or psychological counseling may be necessary for patients with continuing problems. (American Family Physician 2006;74:1159-64, 1165-66. Copyright © 2006 American Academy of Family Physicians.)

3.4
The CONTRACTOR 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 substance abuse treatment services must be available statewide in accordance with accessibility standards in the RFP and resultant Contract. Members do not need a referral to access substance use disorder treatment services.

3.5
The CONTRACTOR shall be responsible for covering services related to the following:
3.5.1
The diagnosis and treatment of substance use disorders,
3.5.2
The ability to achieve age-appropriate growth and development, and
3.5.3
The ability to attain, maintain or regain functional capacity.

4.0 Mental Health Services

The CONTRACTOR(S) will provide all medically necessary services to Members accessing care through the mental health (MH) service system. 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 CPST, and Family Psycho-education. Outpatient examples include Dialectical Behavior Therapy, Cognitive Behavioral Therapy and Shared Decision Making. The contractor 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

4.4
Assessment of qualification for the target population as defined through the Severely Persistently Mental Health (SPMI) Risk Assessment and the Serious Emotional Disturbance (SED) Determination
4.4.1
These tools may be found at:

4. 4.1.1
SED waiver application and other forms: https://www.kansashealthsolutions.org/providers/index/resources_forms
4. 4.1.2
SPMI Assessment: http://www.srs.ks.gov/agency/mh/Documents/OutcomesReports/aims_v30entire_revjune272005.pdf

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

4.6
Targeted Case Management (TCM)

4.7
Screening and Assessment for risk of inpatient care

4.8
Supports and Services as defined in the most recently approved 1915 c HCBS SED Waiver

4.9
Services and supports in a frequency, support and duration that supports and maintains the individuals opportunity to remain in their home and community

4.10
Treatment Planning that includes the consumer/Member/family's involvement in the development of goals, interventions and scope of service

4.11
Crisis Response and Intervention Services that ameliorate the risk for harm to self or others when the Member self identifies as in crisis

4.12
Services and supports within the applicable limits and service units as identified in the tables below

4.12.1

T-XIX Funded Mental Health Services	T-XIX Members	
	State Plan Only Enrollees	HCBS SED Waiver
Outpatient Therapy and Medication Management Services		
Evaluation and Assessment	X	X
Testing	X	X
Individual Therapy	X	X
Family Therapy	X	X
Group Therapy	X	X
Medication Management	X	X
Medication Administration	X	X
Case Consultation	X	X
Rehabilitation Services		
Community Psychiatric Support and Treatment	X	X
Psychosocial Rehabilitation	X	X
Peer Support	X	X
Crisis Intervention	X	X
Targeted Case Management		
Targeted Case Management for the SPMI/SED populations	X	X
Kan-be-Healthy		
Evaluation and Assessment	X	X

Service Plan Development	X	X
HCBS SED Waiver Services		
Parent Support and Training		X
Independent Living / Skills Building		X
Short Term Respite Care		X
Wrap Around Facilitation		X
Professional Resource Family Care		X
Attendant Care		X
1915 (b) 3 Services		
Attendant Care	X	
Case Consultation	X	X

4.12.2

Attendant Care [§1915(b)]

Definition

Attendant Care is a service provided individuals who would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the individual to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness.

Components

1. Assistance is in the form of direct support, supervision and/or cuing so that the Member performs the task by him/her self.
   - Such assistance most often relates to performance of Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community.
2. Services should generally occur in community locations where the individual lives, works, attends school, and/or socializes.
   - Services provided at a work site must not be job tasks oriented.
   - Services provided in an educational setting must not be educational in purpose.
3. Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are non-covered.
4. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the Member's individualized plan of care.
5. Transportation is provided between the participant's place of residence and other service sites or places in the community, and the cost of transportation is included in the rate paid to providers of this services.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 18 years of age and at least 3 years older than the youth. • Completion of state approved training according to the curriculum approved by SRS prior to providing the service. • Pass KBI, SRS child abuse check, adult abuse registry, and motor vehicle screens.	• Meets functional assessment criteria for target population. • Individuals approved for HCBS SED Waiver §1915(c) Attendant Care but not §1915(b) Attendant Care.

Limitations/Exclusions	Allowed Mode(s) of Delivery
• Services must be prior authorized. • Attendant Care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. The attendant care worker must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated Licensed Mental Health Professional (LMHP) with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier (1)	Modifier (2)	Provider Qual.	Tx. Context	Description
T1019				Ind.	Attendant Care – 1915(b)

4.12.3

Case Conference [§1915(b)]

Definition

A case conference is a scheduled face-to-face meeting to discuss problems associated with the individual's treatment. The conference may include treatment staff, collateral contact, or the individual's other agency representatives, not including court appearances and/or testimony.

Provider Qualifications	Eligibility Criteria
• Mental Health Professional licensed to practice independently: o licensed psychologist o licensed clinical marriage and family therapist, o licensed clinical professional counselor, o licensed specialist clinical social worker, or o licensed clinical psychotherapist. • And a Mental Health Professional licensed to practice under supervision or direction: o licensed masters marriage and family therapist, o licensed masters professional counselor, o licensed masters social worker, or o licensed masters level psychologist. • And a physician, or a physician assistant or advanced registered nurse practitioner working under protocol of a physician. • Supervision must be provided by a person eligible to provide Medicaid services and who is licensed at the clinical level or who is a physician. All service must be rendered within the scope of the provider's professional license.	• Meets functional assessment criteria for target population.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Services must be prior authorized. • Services which exceed the limitation of the initial authorization must be approved for re-authorization.	• On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Case Conference does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
99366					Case conference as medical team conference with interdisciplinary team of health care professionals, face- to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professionals.
99367					Case conference as a medical team conference with interdisciplinary team of health care professionals, with patient and/or family not present, 30 minutes or more, participation by a physician.
99368					Case conference as a medical team conference with interdisciplinary team of health care professionals, with patient and or family not present, 30 minutes or more, participation by non-physician qualified health care.

4.12.4

Early Childhood Mental Health Assessment Services	
Definition	
Mental Health and Behavioral Health screening, diagnosis, and treatment services for children ages 0 through 5 years not included elsewhere in the plan.	
Provider Qualifications	**Eligibility Criteria**
• An employee of a Community Mental Health Center meeting the criteria of a Qualified Mental Health Professional. • Supervision must be provided by a person eligible to provide Medicaid services and who is licensed at the clinical level or who is a physician. All service must be rendered within the scope of the provider's professional license. • Core Competencies in Early Childhood Mental Health as defined by State of Kansas.	All Medicaid-eligible children ages 0 through 5 years who meet medical necessity criteria.
Limitations/Exclusions	**Allowed Modes of Delivery**
• All services have an initial authorization level of benefit. Services, which exceed the limitation of the initial authorization, must be approved for re-authorization prior to service delivery. o Two mental health assessments which include observation are authorized per benefit year.	• On-site • Off-site
Additional Service Criteria	
1. Providers must obtain consent for assessment and/or treatment from the parent, guardian, or legal custodian. 2. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's treatment plan. 3. Prior to receipt of Early Childhood mental health/behavioral health services, a physician or other licensed mental health professional experienced in the diagnosis of mental disorders must provide written certification that: • The child meets the eligibility criteria listed above; • The services are medically necessary for the treatment of the recipient's mental health; • The child's condition or functional level cannot be improved with less intensive services.	

Reimbursement and Coding Summary

CPT / HCPCS Code	Modifier		Description
	(1)	(2)	
96150			Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires) each 15 minutes face-to-face with the patient; initial assessment.
H0031			Mental health assessment by non-physician, extended (standardized assessment with interpretation and report including clinical observation for more than 3 hrs.)
H0032			Mental health service plan development by an LMHP in conjunction with the family and significant others and with other systems of care such as early education, child care, child welfare.

4.12.5

Outpatient Therapy	
Definition	
Individual, Family, Group Outpatient Psychotherapy	
Provider Qualifications	**Eligibility Criteria**
• Mental Health Professional licensed to practice independently: o licensed psychologist, o licensed clinical marriage and family therapist, o licensed clinical professional counselor, o licensed specialist clinical social worker, or o licensed clinical psychotherapist. • And a Mental Health Professional licensed to practice under supervision or direction: o licensed masters marriage and family therapist, o licensed masters professional counselor, o licensed masters social worker, or o licensed masters level psychologist. • And a physician, or a physician assistant or advanced registered nurse practitioner working under protocol of a physician. • Supervision must be provided by a person eligible to provide Medicaid services and who is licensed at the clinical level or who is a physician. All service must be rendered within the scope of the provider's professional license. • In addition to a professional license, providers of 90847HK must complete state approved training in the provision of home based family therapy.	• All Medicaid eligible individuals who meet medical necessity criteria.
Additional Service Criteria	**Allowed Mode(s) of Delivery**
Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.	• Individual • Family • Group • On-site • Off-site • Televideo

Reimbursement and Coding Summary

CPT / HCPCS Code	Modifier		Description
	(1)	(2)	
90804			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, on-site or off-site, face-to-face with the Member
90806			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, on-site or off-site, face-to-face with the Member
90808			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, on-site or off-site, face-to-face with the Member
90810			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the Member
90812			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the Member
90814			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the Member
90816			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the Member
90818			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with

			the Member
90821			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the Member
90823			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the Member
90826			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the Member
90828			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting
90847			Family psychotherapy (conjoint psychotherapy) (with Member present)
90847	HK		Family psychotherapy (conjoint psychotherapy) (with Member present) provided in the home or community
90853			Group psychotherapy (other than of a multiple-family group)
Telemedicine: Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face to face service. The originating site, with the Member present, may bill code Q3014 (telemedicine originating site facility fee).			

Outpatient Therapy

Definition

Mental Health Assessment, Evaluation, and Testing

Provider Qualifications	Eligibility Criteria
• Mental Health Professional licensed to practice independently: o licensed psychologist, o licensed clinical marriage and family therapist, o licensed clinical professional counselor, o licensed specialist clinical social worker, or o licensed clinical psychotherapist. • And a Mental Health Professional licensed to practice under supervision or direction: o licensed masters marriage and family therapist, o licensed masters professional counselor, o licensed masters social worker, or o licensed masters level psychologist. • And a physician, or a physician assistant or advanced registered nurse practitioner working under protocol of a physician. • Supervision must be provided by a person eligible to provide Medicaid services and who is licensed at the clinical level or who is a physician. All service must be rendered within the scope of the provider's professional license. • In addition to a professional license, providers of 90847HK must complete state approved training in the provision of home based family therapy.	• All Medicaid eligible individuals who meet medical necessity criteria.

Additional Service Criteria	Allowed Mode(s) of Delivery
Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.	• Individual • Family • Group • On-site • Off-site • Televideo

Reimbursement and Coding Summary

CPT/ HCPS Code	Modifier		Description
	(1)	(2)	
90801			Admission Evaluation - Psychiatric diagnostic interview examination
90802			Admission Evaluation - Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
96101			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, Minnesota Multiphasic Personality Inventory (MMPI), Rorschach, Wechsler Adult Intelligence Scale (WAIS),) per hour of the psychologist's or physician's time, both face to face administering tests to the Member, and time interpreting these test results and preparing the report
96102			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS,) with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face to face with the Member
96103			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI) administered by computer, with qualified health care professional interpretation and report

96118			Neuropsychological testing (eg Halstead-Reitan Neuropsychological Battery, Weschler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the Member and time interpreting these results and preparing the report, face to face.
96119			Neuropsychological testing (eg Halstead-Reitan Neuropsychological Battery, Weschler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face to face
96120			Neuropsychological testing (eg Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
Telemedicine: Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face to face service. The originating site, with the Member present, may bill code Q3014 (telemedicine originating site facility fee).			

4.12.7

Outpatient Medical Services

Definition
Individual Therapy with Medical Evaluation and Management, Medication Management, and Medication Administration

Provider Qualifications	Eligibility Criteria
• Physician or PA / ARNP working under protocol of a physician. • RN working within the scope of practice.	• All Medicaid eligibles who meet medical necessity criteria.

Limitations/Exclusions	Allowed Mode(s) of Delivery
• Presenting conditions must meet the Kansas definition of medical necessity as defined in the CONTRACTOR(S) contract.	• Individual • On-site • Off-site • Televideo

Additional Service Criteria
Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

Reimbursement and Coding Summary

CPT / HCPCS Code	Modifier		Description
	(1)	(2)	
90805			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility face to face with the Member with medical evaluation and management services
90807			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility face to face with the Member with medical evaluation and management services
90809			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility face to face with the Member with medical evaluation and management services
90811			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility with medical evaluation and management services.
90813			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility face to face with the Member with medical evaluation and management services
90815			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility face to face with the Member with medical evaluation and management services
90817			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting face to face with the Member with medical evaluation and management services
90819			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting face to face with the Member with medical evaluation and management services
90822			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting face to face with the Member with medical evaluation and management services
90824			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an

			inpatient hospital, partial hospital or residential care setting face to face with the Member with medical evaluation and management services
90827			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting face to face with the Member with medical evaluation and management services
90829			Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting face to face with the Member with medical evaluation and management services
90862			Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
96372			Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (patient supplies own medication)
J0515			Injection, Benztropine Mesylate, per 1 mg.
J1631			Injection, Haloperidol Decanoate, per 50 mg
J2680			Injection, Fluphenazine Decanoate up to 25 mg
J2426			Injection, Paliperidone Palmitate extended release, 1MG
J2794			Injection, Risperidone, Long Acting, 0.5 mg.
J3490			Unclassified Drugs
Telemedicine: Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face to face service. The originating site, with the Member present, may bill code Q3014 (telemedicine originating site facility fee). Rendering Provider: Medical Services claimed with an ARNP or PA as the rendering provider are reimbursed at 75% of the rate reimbursed to an MD.			

4.12.8

Outpatient Medical Services	
Definition	
Psychiatric Evaluation and Case Consultation	
Provider Qualifications	**Eligibility Criteria**
• Physician or PA /ARNP working under protocol of a physician. • RN working within the scope of practice.	• All Medicaid eligibles who meet medical necessity criteria.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Presenting conditions must meet the Kansas definition of medical necessity as defined in the CONTRACTOR(S) contract.	• Individual • On-site • Off-site • Televideo
Additional Service Criteria	
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.	

Reimbursement and Coding Summary

CPT / HCPCS Code	Modifier		Description
	(1)	(2)	
99201			Office or other outpatient visit, for the evaluation and management of a new patient, which requires these three key components: • a problem focused history, • a problem focused examination; and • straightforward medical decision making. Usually the presenting problem(s) are self limited or minor.
99202			Office or other outpatient visit, for the evaluation and management of a new patient, which requires these three key components: • an expanded problem focused history, • an expanded problem focused examination; and • straightforward medical decision making. Usually the presenting problem(s) are of low to moderate severity.
99203			Office or other outpatient visit, for the evaluation and management of a new patient, which requires these three key components: • a detailed history, • a detailed examination; and • medical decision making of low complexity. Usually the presenting problem(s) are of low complexity.
99204			Office or other outpatient visit, for the evaluation and management of a new patient, which requires these three key components: • a comprehensive history, • a comprehensive examination; and • medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high complexity.
99205			Office or other outpatient visit, for the evaluation and management of a new patient, which requires these three key components: • a comprehensive history, • a comprehensive examination; and • medical decision making of high complexity. Usually the presenting problem(s) are of moderate to high complexity.
99211			Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal.
99212			Office or other outpatient visit, for the evaluation and management of an

			established patient, which requires at least 2 of these 3 key components: • a problem focused history, • a problem focused examination; and • straightforward medical decision making. Usually the presenting problem(s) are self limited or minor.
99213			Office or other outpatient visit, for the evaluation and management of an established patient, which requires at least two of these three components: • an expanded problem focused history, • a expanded problem focused examination; and • medical decision making of low complexity. Usually the presenting problem(s) are of low to moderate complexity.
99214			Office or other outpatient visit, for the evaluation and management of an established patient, which requires at least two of these three components: • a detailed history, • a detailed examination; and • medical decision making of moderate to high complexity. Usually the presenting problem(s) are of moderate to high severity.
99215			Office or other outpatient visit, for the evaluation and management of an established patient, which requires at least two of these three components: • a comprehensive history, • a comprehensive examination; and • medical decision making of high complexity. Usually the presenting problem(s) are of moderate to high complexity.
99221			Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a detailed or comprehensive history, • a detailed or comprehensive examination; and • medical decision making that is straightforward or of low complexity. Usually the problem(s) requiring admission are of low severity.
99222			Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history, • a comprehensive examination; and • medical decision making that is of moderate complexity. Usually the problem(s) requiring admission are of moderate severity.
99223			Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history, • a comprehensive examination; and • medical decision making of high complexity. Usually the problem(s) requiring admission are of high severity.
99304			Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: • a detailed or comprehensive history, • a detailed or comprehensive examination; and • medical decision making that is straightforward or of low complexity. Usually the problem(s) requiring admission are of low severity.
99305			Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history, • a comprehensive examination; and • medical decision making that is of moderate complexity. Usually the problem(s) requiring admission are of moderate severity.
99306			Initial consultation – nursing facility for the evaluation and management of a patient which requires these three key components: • a comprehensive history, • a comprehensive examination; and • medical decision making that is of high complexity.

			Usually the problem(s) requiring admission are of high severity.
Telemedicine: Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face to face service. The originating site, with the Member present, may bill code Q3014 (telemedicine originating site facility fee). Rendering Provider: Medical Services claimed with an ARNP or PA as the rendering provider are reimbursed at 75% of the rate reimbursed to an MD.			

4.12.9

Administrative Codes to Assess Criteria for Admission to Inpatient Psychiatric Treatment	
Definition	
Initial Inpatient Screen, Follow-up Screen, and CBST Meeting	
Provider Qualifications	**Eligibility Criteria**
• Mental Health Professional licensed to practice independently: o licensed psychologist, o licensed clinical marriage and family therapist, o licensed clinical professional counselor, o licensed specialist clinical social worker, or o licensed clinical psychotherapist. • And a Mental Health Professional licensed to practice under supervision or direction: o licensed masters marriage and family therapist, o licensed masters professional counselor, o licensed masters social worker, or o licensed masters level psychologist. • And a physician, or a physician assistant or advanced registered nurse practitioner working under protocol of a physician. • Supervision must be provided by a person eligible to provide Medicaid services and who is licensed at the clinical level or who is a physician. All service must be rendered within the scope of the provider's professional license. • In addition to a professional license, providers of 90847HK must complete state approved training in the provision of home based family therapy.	• All Medicaid eligible individuals who meet medical necessity criteria.

Limitations/Exclusions	Allowed Mode(s) of Delivery
• Presenting conditions must meet the Kansas definition of medical necessity as defined in the CONTRACTOR(S) contract.	• Individual • Family • On-site

Additional Service Criteria
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

Reimbursement and Coding Summary			
CPT / HCPCS Code	Modifier		Modifier
	(1)	(2)	
I0010			Initial Inpatient Screen
I0020			Follow-up Screen
W0010			CBST Meeting

4.12. 10
Rehabilitation Services

4.12.10.1

Community Psychiatric Support and Treatment [CPST]

Definition

Goal directed supports and solution-focused interventions intended to prevent regression of the individual's functioning and to help the individual achieve identified goals or objectives as set forth in his or her individualized treatment plan. CPST is a face-to-face intervention with the Member present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

Components

- Assist the Member and family members or other collaterals to identify strategies or treatment options associated with the Member's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the Member's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the Member, with the goal of assisting the Member with developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- Participation in and utilization of strengths based planning and treatments which include assisting the Member and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.
- Assist the Member with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the Member and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.
- Evidenced Based Practices (EBP) which include integrated dual diagnosis treatment, strength based service delivery, and employment supports are included.

Provider Qualifications	Eligibility Criteria
• Must have a BA/BS degree or four years of equivalent education and/or experience working in the human services field. • Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.	• Meets functional assessment criteria for target population. • Meets Medical Necessity criteria for rehabilitation services

Limitations/Exclusions	Allowed Mode(s) of Delivery
• Ratio: Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and Member satisfaction and must meet the needs identified in the individual treatment plan. The following general ratio (Full time equivalent to Medicaid Eligible) should serve as a guide: o 1 FTE to 15 youth Members o 1 FTE to 25 adult Members	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. EBP's require prior approval and fidelity reviews on an ongoing basis as determined necessary by the State Mental Health Authority.
3. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service

Reimbursement and Coding Summary					
HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
H0036	HA		BA/BS	Ind.	CPST - Child
H0036	HB		BA/BS	Ind.	CPST - Adult
H0036	HH		BA/BS	Ind.	CPST – EBP Integrated Dual Diagnosis
H0036	HJ		BA/BS	Ind.	CPST – EBP Employment Support
H0036	HK		BA/BS	Ind.	CPST – EBP Strength Based

4.12.10.2

Psychosocial Rehabilitation

Definition

Psychosocial Rehabilitation (PR) services are designed to assist the Member with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the Member's individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the Member as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PR is a face-to-face intervention with the Member present. Services may be provided individually or in a group setting. The majority of PR contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

Components

1. Restoration, rehabilitation and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the Member's social environment including home, work and school.
2. Restoration, rehabilitation and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the Member with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
3. Implementing learned skills so the person can remain in a natural community location.
4. Assisting the Member with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider Qualifications	Eligibility Criteria
• Must be at least 18 years old, and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than a Member under the age of 18. • Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.	• Meets functional assessment criteria for target population. • Meets Medical Necessity criteria for rehabilitation services.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Ratio: o 1 FTE to 8 Members is maximum group size for adults o 1 FTE to 4 Members is maximum group size for youth	• Individual • Group • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. The PR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier (1)	Modifier (2)	Provider Qual.	Tx. Context	Description
H2017			HS	Ind	Psychosocial Rehabilitation - Individual
H2017	HQ		HS	Grp	Psychosocial Rehabilitation - Adult Group
H2017	TJ		HS	Grp	Psychosocial Rehabilitation – Child Group

Peer Support

Definition

Peer Support (PS) services are Member centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the Member's individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for Members to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. PS is a face-to-face intervention with the Member present. Services can be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

Components

1. Helping the Member to develop a network for information and support from others who have been through similar experiences.
2. Assisting the Members with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician.
3. Assisting the Member with the identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider Qualifications	Eligibility Criteria
• Must be at least 18 years old, and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than a Member under the age of 18. • Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program. • The provider must self identify as a present or former primary Member of mental health services.	• Meets functional assessment criteria for target population. • Meets Medical Necessity criteria for rehabilitation services
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Ratio: 1 FTE to 8 Members is maximum group size	• Individual • Group • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. The Peer Support provider must be supervised by a person meeting the qualifications for a Peer Support Supervisor and receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
H0038			HS	Ind	Peer Support - Individual
H0038	HQ		HS	Grp	Peer Support - Group

Basic Crisis Intervention

Definition

Basic Crisis Intervention is provided to an individual who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience. Basic Crisis Intervention is provided to an individual in crisis who requires the assistance of another person to regulate behavior. The goals of Basic Crisis Intervention are symptom reduction, stabilization, and restoration to a previous level of functioning. Activities include a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. All activities must occur within the context of a potential or actual psychiatric crisis. Basic Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the individual lives, works, attends school, and/or socializes. Basic Crisis Intervention may occur when assistance is needed to stabilize an individual prior to an emergent screen, during a screen or immediately following a screen.

Components

1. A preliminary assessment of risk, mental status, and medical stability, and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
2. Short-term crisis interventions including crisis resolution and de-briefing with the individual.
3. Follow-up with the individual, and as necessary, with the individual's caregiver and/or family members.
4. Consultation with a physician or with other providers to assist with the individual's specific crisis.

Provider Qualifications	Eligibility Criteria
• Must be at least 20 years old and at least three years older than an individual under the age of 18. • Have an AA/AS degree or two years of equivalent education and/or experience working in the human services field. • Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.	• All individuals who self identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. • An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. • Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.

Limitations/Exclusions	Allowed Mode(s) of Delivery
• For the safety of the Member and staff, H2011can be billed concurrently with H2011(HK) and H2011(HO). Medical necessity for this level of support must be documented in the Member's medical chart. • Basic Crisis Intervention does not have a daily limit. • Re-evaluation for the need of crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation should be maintained in the medical record.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and child welfare. This coordination must be documented in the youth's medical record.
2. The initial preliminary assessment of risk, mental status, and medical stability must be completed by a QMHP or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. The crisis plan developed from this assessment and all services delivered during a crisis must be provided under the supervision of a

QMHP or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such must be available at all times to provide back up, support, and/or consultation.

3. Crisis services cannot be denied based upon substance use. Substance use should be recognized and addressed in an integrated fashion with the statewide substance abuse contractor. This coordination must be documented in the individual's treatment plan.
4. The Crisis Intervention provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier (1)	Modifier (2)	Provider Qual.	Tx. Context	Description
H2011			AA/AS	Ind.	Crisis Intervention – Basic

Intermediate Crisis Intervention

Definition

Intermediate Crisis Intervention is provided to an individual who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience. Intermediate Crisis Intervention is provided to individuals who require the assistance of another person to regulate behavior. The goals of Intermediate Crisis Intervention are symptom reduction, stabilization, and restoration to a previous level of functioning. Activities include a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. All activities must occur within the context of a potential or actual psychiatric crisis. Intermediate Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the individual lives, works, attends school, and/or socializes. Intermediate Crisis Intervention may occur when assistance is needed to stabilize a person prior to an emergent screen, during a screen or immediately following a screen.

Components

1. A preliminary assessment of risk, mental status, and medical stability, and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
2. Short-term crisis interventions including crisis resolution and de-briefing with the individual.
3. Follow-up with the individual, and as necessary, with the individual's caregiver and/or family members.
4. Consultation with a physician or with other providers to assist with the individual's specific crisis

Provider Qualifications	Eligibility Criteria
• Must be at least 20 years old and at least three years older than an individual under the age of 18. • Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience substituting for one year of education. • Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.	• All individuals who self identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. • An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. • Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.

Limitations/Exclusions	Allowed Mode(s) of Delivery
• For the safety of the Member and staff, H2011can be billed concurrently with H2011(HK) and H2011(HO). Medical necessity for this level of support must be documented in the Member's medical chart. • Intermediate Crisis Intervention requires detailed documentation when more than 7 hours occur a day. • Re-evaluation for the need of crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. The re-evaluation will be maintained in the medical record.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and child welfare. This coordination

must be documented in the youth's medical record.

2. The initial preliminary assessment of risk, mental status, and medical stability must be completed by a QMHP or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. The crisis plan developed from this assessment and all services delivered during a crisis must be provided under the supervision of a QMHP or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such must be available at all times to provide back up, support, and/or consultation.
3. Crisis services cannot be denied based upon substance use. Substance use should be recognized and addressed in an integrated fashion with the statewide substance abuse contractor. This coordination must be documented in the individual's treatment plan.
4. The Crisis Intervention provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
H2011	HK		BA/BS	Ind.	Crisis Intervention – Intermediate

Advanced Crisis Intervention

Definition

Advanced Crisis Intervention is provided to an individual who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience. Advanced Crisis Intervention is provided to individuals who require the assistance of another person to regulate behavior. The goals of Advanced Crisis Intervention are symptom reduction, stabilization, and restoration to a previous level of functioning. Activities include a preliminary assessment of risk (which may include an assessment of mental status and the need for further evaluation or other mental health services), immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. This service also includes contact with the client, family member, or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level. All activities must occur within the context of a potential or actual psychiatric crisis. Advanced Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the individual lives, works, attends school, and/or socializes. Advanced Crisis Intervention may occur when assistance is needed to stabilize a person prior to an emergent screen, during a screen or immediately following a screen. This level of intervention includes a clinician utilizing specific treatment interventions such as cognitive behavioral therapeutic techniques that only a clinician can provide.

Components

1. A preliminary assessment of risk, mental status, and medical stability, and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
2. Short-term crisis interventions including crisis resolution and de-briefing with the identified Medicaid eligible Member.
3. Follow-up with the individual, and as necessary, with the individual's caregiver and/or family members.
4. Consultation with a physician or with other providers to assist with the individuals' specific crisis.

Provider Qualifications	Eligibility Criteria
• Must be a QMHP as defined by the state plan or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. • Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.	• All individuals who self identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. • An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. • Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.

Limitations/Exclusions	Allowed Mode(s) of Delivery
• For the safety of the Member and staff, H2011can be billed concurrently with H2011(HK) and H2011(HO). Medical necessity for this level of support must be documented in the Member's medical chart. • Advanced Crisis Intervention requires detailed documentation when more than 3 hours occur a day. • Re-evaluation for the need of crisis services is to be completed by a QMHP every 72 hours or more frequently as needed.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and child welfare. This coordination must be documented in the youth's medical record.
2. The initial preliminary assessment of risk, mental status, and medical stability must be completed by a QMHP or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. The crisis plan developed from this assessment and all services delivered during a crisis must be provided under the supervision of a QMHP or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such must be available at all times to provide back up, support, and/or consultation.
3. Crisis services cannot be denied based upon substance use. Substance use should be recognized and addressed in an integrated fashion with the statewide substance abuse contractor. This coordination must be documented in the individual's treatment plan.
4. The Crisis Intervention provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
H2011	HO		LMHP	Ind.	Crisis Intervention - Advanced

Targeted Case Management [TCM]

Definition

The purpose of Targeted Case Management is to assist adults and children who qualify for this service in maintaining access to needed medical, social, educational, and other services.

Components

1. Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Reviewing Member history and identified needs from initial evaluation/intake form and treatment plan.
   - Identifying the individual's needs and completing related documentation.
   - Gathering information from other sources, such as family members, medical providers, social workers and educators (if necessary), to form a complete assessment of the individual.
2. Development of a specific care plan that:
   - Is based on the information collected through the assessment.
   - Specifies the goals and actions to address accessing the medical, social, educational and other services needed by the individual.
   - Includes such activities as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision-maker) and others to develop these goals.
   - Identifies a course of action to respond to the assessed needs of the eligible individual.
   - Has on-going monitoring over service provision to ensure the Member is receiving the identified services on the treatment plan.
3. Referral and related activities:
   - To help an eligible individual obtain and maintain needed services including activities that help link an individual with:
   - Medical, social, educational providers; or
   - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
4. Monitoring and follow-up activities:
   - Activities and contact necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities and contact may be with the individual, his or her family members, providers and other entities or individuals and may be conducted as frequently as necessary, including at least one annual monitoring to ensure the following conditions are met:
     - Services are being furnished in accordance with the individual's treatment plan.
     - Services in the treatment plan are adequate
     - If there are changes in the needs or status of the individual, necessary adjustments are made to the treatment plan and to service arrangements with providers.
5. Targeted case management may include contact with non-eligible individuals who are directly related to identifying the needs and supports for helping the eligible individual to access services. (i.e., the TCM provider need not be in direct contact with the identified Member to bill for TCM.)
6. No physician's signature is required to bill TCM, but the physician should be aware of care coordination needs.

Provider Qualifications	Eligibility Criteria
• Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education, with one year of experience substituting for one year of education; • Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and the ability to react effectively in a wide variety of human service situations. • Meet the specifications outlined in the CMHC licensing standards in	• Meets functional assessment criteria for target population.

regard to any ongoing requirements (as in completion of the training requirements according to a state approved curriculum. • Pass Kansas Bureau of Investigation (KBI), SRS child abuse check, adult abuse registry and motor vehicle screens.	
Limitations/Exclusions	Allowed Mode(s) of Delivery
• Caseload size must be based on the needs of the clients/families with an emphasis on successful outcomes and Member satisfaction and must meet the needs identified in the individual treatment plan. A general guide is to have one full-time equivalent TCM staff for 35 persons served. o Targeted Case management services will be provided in a manner consistent with the best interest of recipients. o Receiving TCM will not restrict an individual's access to other services under the plan. • Other Medicaid services cannot be held contingent upon the receipt of TCM and TCM cannot be held contingent upon the receipt of other Medicaid services. • Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. • Targeted Case Management does not include the following: o The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. o Activities integral to the administration of foster care programs; or o Activities for which third parties are liable to pay.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and child welfare. This coordination must be documented in the youth's medical record.
2. The TCM provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
T1017			BA/BS	Ind.	Targeted Case Management – Mental Health

4.12.12.1

Parent Support and Training

Definition

Parent Support and Training is designed to benefit participants experiencing a serious emotional disturbance who without waiver services would require state psychiatric hospitalization or psychiatric residential treatment facility treatment. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the participant. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver or grant, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Components

1. Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the participant in relation to their mental illness and treatment;
2. Development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the participant's symptom/behavior management;
3. Assisting the family in understanding various requirements of the waiver or grant process, such as the crisis plan and plan of care process;
4. Training on the participant’s medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the participant with mental illness while living in the community.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 21 years of age. • Preference is given to parents or caregivers of children with SED. • Completion of Parent Support training according to a curriculum approved by SRS within one year of hire as a Parent Support provider. • Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens	• HCBS SED Waiver

Limitations/Exclusions	Allowed Mode(s) of Delivery
• Service requires prior authorization • 1 FTE to 10 participants / families is maximum group size. • Parent Support and Training will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.	• Family • Group • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth’s medical record.
2. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
S5110				Ind	Parent Support and Training – Ind
S5110	TJ			Grp	Parent Support and Training - Group

Independent Living / Skills Building

Definition

Independent Living/Skills Building services are designed to assist participants who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings.

Components

1. Independent Living/Skills Building activities are provided in partnership with participants to help the participant arrange for the services they need to become employed, find transportation, housing, and continue their education.
2. Services are individualized according to each participant's strengths, interests, skills, goals as specified in the Plan of Care.
3. It would be expected that Independent Living/ Skills Building activities take place in the community.
4. This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living.
5. Housekeeping, homemaking (shopping, child care, and laundry services), or basic services solely for the convenience of a participant receiving independent living / skills building are not covered.
6. The following are examples of appropriate community settings rather than an all inclusive list:
   - a grocery store to shop for food,
   - a clothing store to teach the participant what type of clothing is appropriate for interviews,
   - an unemployment office to assist in seeking jobs or assist the participant in completing applications for jobs,
   - apartment complexes to seek out housing opportunities, and
   - laundry mats to teach the participant how to wash clothing.
7. Other appropriate activities can be provided in any other community setting as identified through the Plan of Care process.
8. Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this service.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 21 years of age. • Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens. • Completion of an approved training in the skills area(s) need by the transitioning youth according to a curriculum approved by SRS prior to providing the service.	• HCBS SED Waiver
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Service requires prior authorization • Independent Living / Skills Building will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation.

Reimbursement and Coding Summary					
HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
T2038				Ind	Independent Living / Skills Building

Short Term Respite Care

Definition

Short Term Respite Care provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to families/caregivers of a participant with a serious emotional disturbance.

Components

1. The service is designed to help meet the needs of the primary caregiver as well as the identified participant.
2. Normal activities of daily living are considered content of the service when providing respite care, and these include:
   - support in the home, after school, or at night,
   - transportation to and from school, medical appointments, or other community-based activities,
   - and/or any combination of the above.
3. Short Term Respite Care can be provided in an individual's home or place of residence or provided in other community settings.
4. Other community settings include:
   - Licensed Family Foster Home,
   - Licensed Crisis House,
   - Licensed Emergency Shelter,
   - Out-of-Home Crisis Stabilization House/Unit/Bed.
5. Respite Services provided by or in an institution for mental disease (IMD) are non-covered.
6. The participant must be present when providing Short Term Respite Care.
7. The cost of transportation is included in the rate paid to providers of these services.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 21 years of age. • Completion of respite training according to the curriculum approved by SRS prior to providing the service. • Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens. • Certification in: First Aid, CPR, Crisis Prevention / Management (example: Crisis Prevention Istitute (CPI), Mandt, etc.)	• HCBS SED Waiver

Limitations/Exclusions	Allowed Mode(s) of Delivery
• Service requires prior authorization • Short Term Respite Care may not be provided simultaneously with Professional Resource Family Care services. • Short Term Respite Care is not available to participants in foster care because that service is available through child welfare contractors. • Short Term Respite Care will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation.

Reimbursement and Coding Summary

HCPCS Code	Modifier (1)	Modifier (2)	Provider Qual.	Tx. Context	Description
S5150				Ind	Short Term Respite Care

Wraparound Facilitation

Definition

The function of the wraparound facilitator is to form the wraparound team consisting of the participant's family, extended family, and other community members involved with the participant's daily life for the purpose of producing a community-based, individualized Plan of Care. This includes working with the family to identify who should be involved in the wraparound team and assembly of the wraparound team for the Plan of Care development meeting.

Components

1. The wraparound facilitator guides the Plan of Care development process of the team to assure that waiver or grant rules are followed.
2. The wraparound facilitator also is responsible for reassembling the team when subsequent Plan of Care review and revision are needed, at minimum on a yearly basis to review the Plan of Care and more frequently when changes in the participant's circumstances warrant changes in the Plan of Care.
3. The wraparound facilitator will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the participant and family/caregivers.
4. Facilitators will be certified after completion of specialized training in the wraparound philosophy, waiver/grant rules and processes, waiver/grant eligibility and associated paperwork, structure of the participant and family team, and meeting facilitation.

Provider Qualifications	Eligibility Criteria
• Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience substituting for one year of education. • Completion of Wraparound Facilitation/ Community Support Training according to a curriculum approved by SRS within 6 months of hire. • Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens.	• HCBS SED Waiver
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Service requires prior authorization • Wraparound Facilitation is provided in addition to targeted case management to address the unique needs of waiver/grant clients living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the recipient at no cost.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
H2021				Ind	Wraparound Facilitation

Professional Resource Family Care

Definition

Professional Resource Family Care is intended to provide short-term and intensive supportive resources for the participant and his or her family. This service offers intensive family-based support for the participant's family through the utilization of a co-parenting approach provided to the participant in a surrogate family setting.

Components

1. The goal is to support the participant and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time.
2. During the time the professional resource family is supporting the participant, there is regular contact with the family to prepare for the participant's return and his or her ongoing needs as part of the family.
3. It is expected that the participant, family and the professional resource family are integral members of the participant's individual treatment team.
4. Transportation is provided between the participant's place of residence and other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this services.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 21 years of age. • Completion of state approved training according to a curriculum approved by SRS prior to providing the service. • Pass KBI, SRS child abuse check, adult abuse registry, and motor vehicle screens. • Family Home Setting licensed by Kansas Department Health and Environment. • Certification in: First Aid, CPR, Crisis Prevention / Management (example: CPI, Mandt, etc.)	• HCBS SED Waiver
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Service requires prior authorization. • Professional Resource Family Care may not be provided simultaneously with Short Term Respite Care services. • Professional Resource Family Care is not available to participants in foster care because that service is available through Child Welfare Contractors. • Professional Resource Family Care may not be provided simultaneously with Short Term Respite care and does not duplicate any other Medicaid State Plan service or service otherwise available to recipient at no cost.	• Individual • On-site • Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) or CONTRACTOR(S)-designated LMHP with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation.

Reimbursement and Coding Summary

HCPCS Code	Modifier		Provider Qual.	Tx. Context	Description
	(1)	(2)			
S9485				Ind	Professional Resource Family Care

4.12.12.6

Attendant Care [§1915(c)]

Definition

Attendant Care is a service provided to participants who would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the participant to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness.

Components

1. Assistance is in the form of direct support, supervision and/or cuing so that the participant performs the task by him/herself.
   - Such assistance most often relates to performance of Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community.
2. Services should generally occur in community locations where the participant lives, works, attends school, and/or socializes.
   - Services provided at a work site must not be job tasks oriented.
   - Services provided in an educational setting must not be educational in purpose.
3. Services furnished to a participant who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are non-covered.
4. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the participant's individualized plan of care.
5. Transportation is provided between the participant's place of residence and other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this services.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 18 years of age and at least 3 years older than the youth. • Completion of state approved training according to the curriculum approved by SRS prior to providing the service. • Pass KBI, SRS child abuse check, adult abuse registry, and motor vehicle screens.	• HCBS SED Waiver
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
• Services must be prior authorized. • Attendant Care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.	• Individual • On-site • Off-site

Additional Service Criteria

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

HCPCS Code	Modifier (1)	Modifier (2)	Provider Qual.	Tx. Context	Description
T1019	HK			Ind.	Attendant Care—SED Waiver

4.13
Psychiatric Residential Treatment Facilities (PRTFs)
4.13.1
PRTFs provide intensive inpatient mental health services to children and youth that meet screening criteria. Admission to a PRTF is based upon the approved screening forms and manual available at https://www.kansashealthsolutions.org/providers/index/clinical_call. The CMHCs licensed clinical staff conduct the assessment for the child or youth's risk factors as defined in the approved screening forms. If all components of the risk criteria are met, the screener will recommend admission. If all components are not met, then a diversion plan will be developed to support the child in their home on community. The diversion plan is expected to contain a robust array of multi-disciplinary services with the goal of successfully and safely maintaining the youth in their home community. Central to the screening process is the Community Based Service Team (CBST) process. The CBST is a multi-disciplinary team that is convened to consider supports and interventions that have previously been in place identify supports and interventions that have not been in place and provide recommendations to the screener to determine if the child and youth is best served in a community or inpatient setting. The result of the CBST is the Alternative Community Services Plan (ACSP) which identifies needed supports and services or documents that all available supports and services have been exhausted. The CBST and ACSP processes are expected to occur simultaneously with the screening process to offer the best opportunity to consider all potential supports, resources and services for the child or youth.
4.13.2
There are 13 PRTFs in the State of Kansas. Additionally, 3 PRTFs in Missouri maintain border agreements with Kansas Medicaid. The total of 16 combined Kansas and Missouri facilities provide approximately 784 beds and operate with an average length of stay of approximately 100 Days. In FY11, total reimbursements for PRTF services were $45,195,029. Averages of 502 individuals are served per month in the PRTF system.

5.0 Home and Community Based Services

Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted.
The following services shall be provided for HCBS waivers, (SED waiver services are described above under Mental Health Services).

5.1
MR/DD Waiver Services
5.1.1
Assistive Services: These are supports or items that meet an individual's assessed need by improving and/or promoting the person's health, independence, productivity or integration into the community and are directly related to the individuals' Person-Centered Support Plan. These services include wheelchair modification, van lifts, communication devices and home modifications.
5.1.2
Day Supports: This service is provided to individuals who are 18 years of age or older and no longer access services through the local education authority. These regularly occurring activities provide a sense of participation accomplishment, personal reward, personal contribution, or remuneration and serve to maintain or increase adaptive capabilities, productivity, independence or integration and participation in the community. These activities include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency and resource identification and acquisition.
5.1.3
Medical Alert Rental: This service provides a support to a Member who has a medical need that could become critical at any time. The medical alert device is a small instrument carried or worn by the Member which, by the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help.

5.1.4
Sleep Cycle Support: The purpose of Sleep Cycle Support is to give overnight medically-related assistance to recipients in case of emergencies or to assist with repositioning.
5.1.5
Specialized Medical Care: This service provides long-term nursing (by an RN or LPN) support for medically-fragile and technology-dependent beneficiaries.
5.1.6
Personal Assistant Services: These are one-to-one supports (attendant care) provided to individuals choosing to self-direct (See Attachment C) their services.
5.1.7
Residential Supports: These supports are provided to persons living in a residential setting (not with someone meeting the definition of family) that include but are not limited to personal grooming, bed making, household chores, eating, and food preparation.
5.1.8
Supported Employment: Supported employment activities are designed to assist individuals with acquiring and maintaining employment.
5.1.9
Supportive Home Care: These are one-to-one supports (attendant care) provided to individuals living with a person who meets the definition of family and may or may not be self-directed.
5.1.10
Overnight Respite Care: is designed to provide relief for the individual's family member who serves as an unpaid primary care giver.
5.1.11
Wellness Monitoring: This support is provided by a Registered Nurse who evaluates the level of wellness of a participant to determine if the person is properly using medical health services as recommended by a physician and if the health of the persons is sufficient to maintain him/her in his/her place of residence.

5.2
PD Waiver Services
5.2.1
Assistive Services
5.2.2
Home-Delivered Meals Service
5.2.3
Medication Reminder Services (Call, dispenser, and dispenser installation)
5.2.4
Personal emergency response system and installation
5.2.5
Personal services self-directed
5.2.6
Personal services agency-directed
5.2.7
Sleep cycle support

5.3
Technology Assisted Waiver Services

State plan services and the institutional comparison model is an acute care hospital. Therefore, the total cost to serve children receiving HCBS/TA services must be equal to or less than the total cost to serve children in a hospital setting. If HCBS/TA waiver program costs are greater, on average, than the total cost to serve children in a hospital setting, Kansas loses the authority to provide services under the HCBS/TA waiver program.

In 2008, under CMS advisement, Kansas amended the waiver to include skilled nursing services previously provided under the State Plan Attendant Care for Independent Living (ACIL) service. The TA waiver includes the service choices listed below.

5.3.1
Independent Case Management (ICM) - Independent Case Management is required for the HCBS TA program waiver. Providers of this service assist Members in gaining access to necessary waiver and other state plan services, as well as necessary medical, social, educational and other services, regardless of the funding source. The qualified case management provider:
5.3.1.1
Serves as the point of access for waiver services
5.3.1.2
Conducts preliminary screening to determine if referral is appropriate
5.3.1.3
Administers initial assessment to determine functional eligibility and reassessments to determine continued eligibility
5.3.1.4
Identifies required service needs, including locating and coordinating services
5.3.1.5
Develops a plan of care (POC) annually with clearly defined goals based on the Member's level of needs
5.3.1.6
Monitors the provision of services
5.3.1.7
Provides technical assistance to families and service providers to carry out program operations
5.3.1.8
Ensures the Member's POC is cost-effective and meets his or her medical needs as well as basic health and safety needs
5.3.1.9
Ensures Member's freedom concerning program waiver choices, services, and providers

5.3.2
Specialized Medical Care (SMC) **-** This service provides long-term nursing support for medically fragile and technology-dependent Members. The required level of care must provide medical support for Members needing ongoing, daily care as in a hospital. The intensive medical needs of the Member must be met to ensure that he or she can choose to live outside of a hospital or institutional setting.
For the purpose of this waiver, a provider of Specialized Medical Care must be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) working under the supervision of a RN. Providers must be trained to deliver skilled nursing services as identified in the POC and within the scope of the State's Nurse Practice Act and meet the medical needs of Members.

5.3.3
Long-term Community Care Attendant- The program offers a choice of agency-directed and self-directed attendant care services, available to Members who choose to remain in their home while living with their medical limitations. These services provide necessary assistance for Members both in their home and community.
Care attendants ensure the health and welfare of the Member while supporting him or her with tasks normally done by a parent, legal guardian, or caretaker. They assist the Member in performing these tasks to promote independence, productivity, and integration.
The functions of an attendant include but are not limited to assisting with:
5.3.3.1
Activities of daily living (ADLs)
5.3.3.1.1
Bathing
5.3.3.1.2
Grooming
5.3.3.1.3
Toileting
5.3.3.1.4
Transferring

5.3.3.2
Health maintenance activities
5.3.3.2.1
Extension of therapies
5.3.3.2.2
Feeding
5.3.3.2.3
Mobility and exercises
5.3.3.2.4
Socialization
5.3.3.2.5
Recreation activities
5.3.3.3
Agency-directed attendant services will be coordinated by the independent case manager and submitted in the electronic POC for prior authorization and approval.
5.3.3.4
Self-directed attendant services will be arranged for, and purchased under, the Member's or legally responsible party's written authority. They will be paid through an enrolled fiscal agent consistent with and not to exceed the Member's POC.

5.3.4
Medical Respite- Medical Respite is a temporary service provided on an intermittent basis to provide the Member's family short, specified periods of relief. Medical respite must be provided in the Member's place of residence. It serves the family by:
5.3.4.1
Meeting nonemergency or emergency family needs
5.3.4.2
Restoring or maintaining the physical and mental well-being of the Member and/or his or her family
5.3.4.3
Providing supervision, companionship, and personal care to the Member

5.3.5
Home Modification Services- For the purpose of the HCBS TA waiver program, home modification services are defined as modifications or adaptations to the Member's home through tangible equipment or hardware, such as adaptive equipment or environmental modifications. The need for a home modification must be identified as necessary to assist the Member in day-to-day functions as indicated in the individualized POC. The goal is to support Members in maintaining their independence, mobility, and productivity in the community.

5.3.6
Intermittent Intensive Medical Care (IIMC) – This service is an RN level of care only. IIMC is designed to meet the Member's intermittent skilled nursing needs when he or she has chosen to meet his or her routine health maintenance care needs with an attendant level of care. It is designed to provide the Member with an additional service choice in order to meet specific skilled nursing care needs that cannot be performed by an attendant. This service is intermittent and must be identified as a medically necessary service in the level of care assessment instrument. These specific nursing care elements are identified in the hydration/specialty care section of the Medical Assistive Technology Level of Care (MATLOC) assessment which include but are not limited to the following:
5.3.6.1
Intravenous (IV) therapy administered less than every four hours daily
5.3.6.2
IV therapy intermittent to be delivered less than four hours per day, weekly or monthly
5.3.6.3
Total parenteral nutrition (TPN) central line delivered less than four hours daily
5.3.6.4

Blood product administered less than four hours, intermittently, weekly or monthly
5.3.6.5
IV pain control less than four hours daily
5.3.6.6
Lab draw each peripheral
5.3.6.7
Lab draw each central
5.3.6.8
Chemotherapy IV or injection
5.3.6.9
Home dialysis administration

5.3.7
Health Maintenance Monitoring (HMM) -- This service is provided in conjunction with agency-directed MST or self-directed PSA attendant care service to provide ongoing evaluation and oversight of the Member's health and welfare status. This service is intended to ensure the Member's medical needs are being met when his or her healthcare is being managed by a non-licensed attendant. Specifically, the service to be provided includes, but is not limited to, the following:
5.3.7.1
Provide general healthcare assessment
5.3.7.2
Assess vital signs
5.3.7.3
Evaluate healthcare management activities
5.3.7.4
Ensure appropriate medication administration
5.3.7.5
Consult with the Member or parent/legal guardian regarding assessment and general healthcare status
5.3.7.6
Report assessment findings to case manager per program protocol
5.3.7.7
May include delegation or supervision of State of Kansas Department of Social and Rehabilitation Services (SRS)-approved health maintenance activities in accordance with the Nurse Practice Act

5.4
Autism Waiver Services
5.4.1
Autism Specialist - Develops the individualized behavioral program plan of care (IBP/POC), develop teaching programs, trains providers and parents on evidence based interventions, monitors the child's progress, makes modifications to IBP/POC on an as need basis, and provides coordination services.
5.4.2
Intensive Individual Supports (IIS) -- Is trained by and works under the direction of the Autism Specialist, provides one-on- one service with the child, and documents service data.
5.4.3
Respite – provides temporary relief to families and caregivers of a child with autism spectrum disorder (ASD).
5.4.4
Parent Support & Training- provides services to enhance the family's coping skills such as problem solving or coping, and develops a strategy for child's symptom and behavior.
5.4.5
Family adjustment Counseling – assists and or guides family members through the process of coping with the child's illness & related stress that accompanies a child with ASD. Families with a child on the ASD have a divorce rate of 80%.
5.4.6
Interpersonal Communication Therapy –this service provides remediate social communications symptoms related to the diagnosis of an autism spectrum disorder.

5.4.7
Functional Eligibility Specialist-- A contracted service in which the awardee is paid a set fee for each determination completed. Per contract the awardee is unable to provide any waiver services therefore creating a conflict free service.

5.5
TBI Waiver Services
5.5.1
Transitional Living Skills - assistance with re-learning lost skills or acquiring new skills that increase independence.
5.5.2
Personal Services - assistance with everyday tasks which the individual would typically do themselves if they did not have a disability, such as dressing, bathing, and cooking.
5.5.3
Assistive Services – medical equipment, home modifications, and assistive technology devices which help individuals remain in their home and increase their level of independence and quality of life.
5.5.4
Rehabilitation Therapies:
5.5.4.1
Physical Therapy
5.5.4.2
Occupational Therapy
5.5.4.3
Speech Therapy
5.5.4.4
Cognitive Rehabilitation
5.5.4.5
Behavior Therapy
5.5.4.6
Sleep Cycle Support - supervision and/or non-nursing physical assistance provided during the individual's normal sleeping hours in their place of residence.
5.5.4.7
Personal Emergency Response System (PERS) - an electronic system which enables certain high-risk individuals to secure help in an emergency

5.6
Frail and Elderly (FE) Waiver Services

Individuals age 65 or older who qualify for Medicaid benefits may be eligible to receive services through the Home and Community Based Services/Frail Elderly program (HCBS/FE). The goal of HCBS/FE is to provide long term care services in the most integrated care setting of the customer's choice. The HCBS/FE program has been administered by the Kansas Department on Aging since July 1, 1997. The HCBS/FE program may enable individuals to stay in their homes or make other successful living arrangements in the community. For further information and a detailed listing of the services provided under the Frail Elderly waiver in the State of Kansas, see Section 3.5 of the Field Service manual located at http://www.aging.ks.gov/Manuals/FSM/Section3.pdf. The following is a partial list of FE Waiver Services:
5.6.1
Adult Day Care
5.6.2
Assistive Technology
5.6.3
Attendant Care
5.6.4
Comprehensive Support
5.6.5

Home Telehealth
5.6.6
Medication Reminder
5.6.7
Nurse Evaluation Visit
5.6.8
Oral Health
5.6.9
Personal Emergency Response
5.6.10
Sleep Cycle Support
5.6.11
Wellness Monitoring

5.7
Money Follows the Person
5.7.1
Money Follows the Person (MFP) is a federal grant designed to support transitioning people from institutional settings back into the community with Home & Community Based Services (HCBS). MFP participants are eligible for all services on the corresponding HCBS waiver for which they are eligible. Populations served with MFP are persons eligible for the MR/DD waiver, Physical Disability (PD) Waiver, Traumatic Brain Injury (TBI) waiver and Frail Elderly (FE) Waiver. In addition to the existing waiver services the following MFP services or enhanced services are also available. The intent is to assure that barriers to successful transition are addressed with these additional services & the flexible benefits they can offer. Benefits include:
5.7.1.1
Transition service
5.7.1.2
Transition Coordination Service
5.7.1.3
Therapeutic Support (MR/DD & TBI only)
5.7.1.4
Community Bridge Building
5.7.1.5
Community Transitions Opportunities Counseling
5.7.1.6
Assistive Services (existing waiver service but MFP specific benefits) include: money spent does not count against HCBS lifetime limits, no individual limit- intent is to set people up for success while receiving grant services, POC does not have to be reduced to cover cost).
5.7.2
A separate demonstration 1915(c) waiver will not be created for the MFP Demonstration. After the 12-month demonstration period, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program. Four (4) waivers are currently part of this demonstration—the MR/DD, PD, FE and TBI waivers.
5.7.3
In addition to the existing service array, the MFP demonstration has additional services and funding available to address barriers to successful transition of individuals to community based settings rather than institutional settings. The intent of the MFP enhancements & additional services is to provide flexibility in order to address individualized needs of program participants. The purpose of the grant is to overcome barriers to successful transition on an individualized basis. Therefore there are soft limits on quantity of and duration of services within the MFP demonstration, with all approvals for MFP services and supports being approved by the MFP Project Director with Kansas Social & Rehabilitative Services (SRS) or her counterpart at the Kansas Department on Aging. While in aggregate most services for MFP participants cost less in the community, there are many individuals for whom their community service costs exceed the cost of institutional care. These individual with higher support costs are a target population for MFP and are eligible for enhanced waiver services and additional MFP services throughout

the 365 of demonstration participation. Upon completion of their 365 days, it is required that the same level of support through waiver services is provided on the corresponding HCBS waiver. The only services that are available only during the demonstration year are the MFP demonstration & supplemental services. Below is a list of the additional or enhanced services available under the MFP demonstration grant.

5.7.3.1

Continuity of Care

MFP Demonstration participants will be accessing services that mirror established 1915(c) waivers, which the state will provide under our demonstration authority. In the post demonstration period, participants will transition to existing 1915 (c) waivers as long as they continue to meet the eligibility criteria. Eligibility and assessment tools are identical for the demonstration project as the established 1915(c) waivers. Therefore, there will no lapse in services for MFP Demonstration participants and a transition plan is not required.

5.7.3.2

After the MFP Demonstration period, if an individual does not meet the institutional level of care requirement or medical necessity, that individual would not be eligible to participate in any of the Medicaid 1915(c) waiver programs. This can only occur if an individual's level of care score had changed, because eligibility and assessment processes are the same for services offered during the demonstration period and for services offered on the 1915 (c) waiver. However, if the individual met Medicaid financial eligibility, and the functional eligibility criteria for Kansas' state plan programs, then the state will assist that individual in the enrollment of one of those programs. If Medicaid financial eligibility is not met, the individual will be assessed to determine eligibility for services available under the Older American Act or programs, and/or Kansas' state general funded services.

Home and Community-Based (Section 1915(c)) – for participants eligible for "qualified home and community-based program" services, provide evidence that:

i. *Slots are available under the cap;*

ii. *A new waiver will be created; or*

iii. *There is a mechanism to reserve a specified number of slots via an amendment to the current 1915(c) waiver.*

All necessary waiver slots are currently available or have been budgeted for in Kansas. Though our waivers do allow for waiting lists MFP participants will by-pass any waiting lists. MFP demonstration participants are assured services on the existing 1915 (c) waivers upon completion of their 365 days of demonstration services. There will be no waiting lists for any person transitioning from MFP to existing waiver programs/services.

No new waiver will be created. All MFP participants will transition from a qualified institution back to the community with long-term services and supports provided under our demonstration authority which mirror the existing 1915(c) Medicaid waivers. Services will continue for MFP participants as long as they desire to remain in the community and meet the eligibility criteria.

5.7.4

MFP Demonstration Benchmarks

Kansas, through utilization of the MFP demonstration project, will implement the following benchmarks. These proposed benchmarks represent the goals identified during pre-implementation planning.

5.7.4.1

Reduction in the Number of Private- Licensed ICFs/MR Facilities and Certified Beds

Kansas currently has 262 individuals living in licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). SRS has targeted all private (ICF/MR) beds for voluntary closure. All current operators will be recruited to voluntarily close their facilities in accordance with current voluntary policies. SRS, in conjunction with KDOA, will work with these providers to close beds behind individuals who enter the MFP demonstration project. Incentive dollars will be offered to providers who agree to voluntarily close all currently occupied ICF/MR beds and cease providing ICF/MR licensed services at that facility and that do not request to open new beds in Kansas.

5.7.4.1.1

Kansas will utilize demonstration enhanced matching funds to ensure access to slots on the MR/DD waiver. In some cases, enhanced dollars will be used to offset additional costs for community living for individuals with extraordinary support needs. While enrolled in the demonstration, these individuals will have access to supplemental service entitled “therapeutic support”. Kansas/SRS is committed to maintaining appropriate supports beyond the demonstration so that these individuals can continue to receive community based services upon exiting the demonstration project.
5.7.4.1.2
Current ICF/MR providers who intend to become licensed HCBS providers will need specialized training for their staff. SRS will arrange training for staff who previously worked in ICF/MR facilities. This training will include the philosophical differences between institutional and home and community services. The training will also address person centered planning, self-direction, consumer rights & responsibilities as well as independence and productivity in natural community settings. The desired goal of the training is to ensure that staff members understand that every person has the opportunity to live as independently as possible.
5.7.4.1.3
Successful achievement of this benchmark will demonstrate:
5.7.4.1.3.1
Overall reduction of the number of occupied ICF/MR beds by at least 80%.
5.7.4.1.3.2
Reduction of the number of private ICF/MR beds by 40 % at the end of calendar year 2008 with an estimated net remaining balance of 152 occupied beds
5.7.4.1.3.3
Reduction of the number of private ICF/MR beds by an additional 33% (of the total occupied beds as of 1/1/2009) at the end of calendar year 2009, resulting in an estimated net remaining balance of 102 occupied beds
5.7.4.1.3.4
Reduction of the number of private ICF/MR beds by an additional 45% (of the total occupied beds as of 1/1/2010) at the end of calendar year 2010 resulting in an estimated net remaining balance of 56 occupied beds

5.7.4.2
Reduction in the Number of Individuals Requesting the Services of, or Residing in, State Operated ICF/MR settings State Mental Retardation Hospitals (SMRH)
SRS has targeted 95 individuals who currently reside in State Mental Retardation Hospitals to return to their home communities.
5.7.4.2.1
The specific targeted individuals include:
5.7.4.2.1.1
Individuals that have demonstrated the lack of ability to be served successfully in their home communities due to potential sexual offender tendencies
5.7.4.2.1.2
Individuals that have demonstrated the lack of ability to be served successfully in their home communities due to aggressive physical behaviors
5.7.4.2.1.3
Individuals that have demonstrated the lack of ability to be served successfully in their home communities due to social or anti-social tendencies
5.7.4.2.1.4
Individuals, that although they qualify for ICF/MR settings, could be successfully served in their home communities if the individuals' parents, guardians, and/or support networks were satisfied that the HCBS community service providers would have the continuing ability to successfully serve their sons, daughters, siblings, or wards.
5.7.4.2.2
Kansas will utilize enhanced community service dollars:
5.7.4.2.2.1
To off-set additional costs for community living for individuals with extraordinary support needs. While enrolled in the demonstration, these individuals will have access to demonstration services entitled

“therapeutic support”. This service will include behavioral support consultation, which will be utilized to provide specialized training of staff persons to support an individual’s unique behavioral issues. Kansas/SRS is committed to maintaining appropriate supports beyond the demonstration so that these individuals can continue to receive home and community services upon exiting the demonstration project.
5.7.4.2.2.2
To provide or to acquire training and/or any qualification or certification necessary to best work with individuals with high behavioral, social, or offender-related needs or tendencies.
5.7.4.2.2.3
To develop support for home and community services and supports targeted toward difficult to serve individuals. Support needs to be developed due to failure of such programs in the past.
5.7.4.2.2.4
To establish an emergency relief / support network that will have the ability to immediately step into highly charged emergency settings to support and stabilize individuals experiencing difficulty.
5.7.4.2.3
The successful achievement of this benchmark will be demonstrated through the following outcomes:
5.7.4.2.3.1
The 5 year average admission requests to the 2 SMRH settings is: 23 admission requests annually
5.7.4.2.3.2
Admission requests will be reduced by 2.5% resulting in no more than 22 admission requests 2008
5.7.4.2.3.3
Admission requests will be reduced by 2.5% resulting in no more than 21 admission requests 2009
5.7.4.2.3.4
Admission requests will be reduced by 2.5% resulting in no more than 20 admission requests 2010
5.7.4.2.3.5
Admission requests will be reduced by 2.5% resulting in no more than 19 admission requests 2011
5.7.4.2.3.6
Overall reduction of 17% of all SMRH referrals

5.7.4.3
Rebalancing Long Term Care Institutional Care Cost in favor of Home and Community Based Services
The state of Kansas will achieve rebalancing through an eight (8) percentage point shift of HCBS spending over institutional costs by the end of the project. The target populations for the demonstration are cross age and cross-disability, including: elderly, physically disabled, persons with traumatic brain injury and individuals in ICF/MR settings, both private and public, and persons residing in State Mental Retardation Hospitals. The Kansas MFP demonstration project projects a reduction in LTC expenditures of over 20 million dollars.
5.7.4.3.1
The successful achievement of this benchmark will be demonstrated through the following outcomes:
5.7.4.3.1.1
2008 47% Institutional 53% HCBS
5.7.4.3.1.2
2009 44% Institutional 57% HCBS
5.7.4.3.1.3
2009 42% Institutional 58% HCBS
5.7.4.3.1.4
2011 41% Institutional 59% HCBS
5.7.4.3.1.5
Overall rebalancing will result in an anticipated 39% Institutional to 61% HCBS which demonstrates an 8% reduction in Institutional expenditures.

5.7.4.4
Annual # of people to transition out of institution settings across all 4 MFP populations is a CMS required benchmark that is re-evaluated annually.

6.0 Services Not Included

The following services are not covered under this contract unless otherwise indicated, but may be covered under Fee-For-Service in T-XIX eligible persons.

6.1
Any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State plan under 1903(i)(1), (2), (16), (17), (18) of the Social Security Act

6.2
Any activities/services in violation of the Assisted Suicide Funding Restriction Act of 1997

6.3
State Institution Services
6.3.1
State Mental Health Hospitals
6.3.2
State mental retardation hospitals that are also public intermediate care facilities for the mentally retarded (ICFs/MR)

6.4
Abortions-- Abortions are covered if:
6.4.1
The pregnancy is the result of an act of rape or incest; or
6.4.2
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.

6.5
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

6.6
Laboratory services performed by the Kansas Department of Health and Environment

6.7
Nursing facilities for mental health

7.0 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.

7.1
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. Such services and programs may include without limitation:
7.1.1
health homes
7.1.2
programs for persons with a dual diagnosis (concurrent substance use disorders and mental illness diagnosis or concurrent developmental disability and mental illness);
7.1.3
programs for persons who are homeless;

7.1.4
programs that promote linkages with primary care providers;
7.1.5
programs that promote the principles of recovery and empowerment, especially programs that involve collaboration with peer advocacy groups, to plan and implement strategies for appropriate recovery and empowerment services for Participants and their families;
7.1.6
substance use disorder treatment programs for youths, pregnant women, and other adults; and
7.1.7
services for youth in the child welfare or juvenile justice system.

7.2
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 T-XIX capitation rates or on the non-T-XIX payments. The CONTRACTOR(S) shall implement those new special services and programs approved by the state and CMS (as necessary). The CONTRACTOR(S) shall work in collaboration with recognized substance use disorder treatment self-help and peer support leaders to provide peer-education and peer-support services for Members through recognized substance use disorder and dual diagnosis (concurrent substance use disorder and mental illness diagnosis) self-help and peer-support leaders.

7.3
CONTRACTOR(S) will ensure SBIRT is incorporated: Early and brief intervention is more clinically effective and much more cost efficient than the traditional more intensive (and expensive) treatment.
7.3.1
Hazardous alcohol and substance use are often undiagnosed by medical professionals and go untreated, leading to more chronic and severe conditions
7.3.2
Negative consequences related to substance use can be attributed to hazardous alcohol and substance use but do not meet criteria for a substance use disorder
7.3.3
SBIRT enhances state substance use disorder treatment services by changing how substance use disorders are managed in primary care settings
7.3.4
SBIRT encourages treating substance use disorder issues at the lowest level of acuity before diagnosis of substance use disorders
7.3.5
SBIRT combines prevention, intervention and treatment toward a consistent continuum of care
7.3.6
SBIRT links primary care (generalists) and substance use disorder care (specialty)
7.3.7
SBIRT increases cost savings

7.4
Conflict-Free Case Management for the PD, TBI, DD and FE waiver services systems
Conflict-Free Case Management as the Centers for Medicare and Medicaid (CMS) defines it: “Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.” It further defined Conflict-Free Case Management: Each enrolled Targeted Case Management (TCM) agency can provide both Financial Management Services (FMS) for self-directed services and TCM, but Members of a specific TCM agency shall select an agency different from the agencies chosen to provide their FMS and applicable self-directed services, agency-directed services, licensed services, and/or services funded by State Aid or county mill levy funds. An agency can provide both TCM and FMS services but cannot provide both services for the same Member.

8.0 Service Definitions

The following definitions for services shall also apply:

8.1.
Private Intermediate Care Facility-Mental Retardation (ICF/MR)
8.1.1
Private Intermediate Care Facility-Mental Retardation (ICF/MR) is defined in 1905(d) of the Act. The Facilities must meet all Federal and State regulations and codes and must be licensed and certified by the Kansas Department on Aging annually. An ICF/MR's primary purpose is the provision of health or rehabilitation services to individuals with Mental Retardation or related conditions receiving care and services under the Medicaid program. The ICF/MR regulations recognize the developmental, social, and behavioral needs of individuals with mental retardation who live in residential settings by requiring that each individual both require and receive active treatment for the ICF/MR care to be eligible for Medicaid funding. There are 26 Private ICF/MR facilities throughout the state of Kansas which are either classified as a small (four to eight beds) or medium size (nine to 16 beds) facility. Statewide there are 162 occupied beds. The ICF/MR is identified as the institutional alternative for the federally approved HCBS MR/DD waiver.

8.2
Nursing Facilities (NF)
The purpose of nursing facilities is to provide health care and related services to individuals requiring 24 hours per day, seven days per week care. Residents receiving services in a nursing facility require ongoing observation, treatment and care for either short or long-term stays due to illness, disease or injury. The CONTRACTOR(S) shall provide long-term nursing facility services to individuals that meet the State's functional eligibility criteria for long-term care and that cannot be safely cared for in a community setting. The contractor shall also provide these services to qualifying individuals that elect to move to a nursing facility.
8.2.1
Nursing facilities in the Medicaid program are required to provide the following services:
8.2.1.1
Licensed nursing supervision 24 hours per day, 7 days per week
8.2.1.2
Specialized rehabilitation services
8.2.1.3
Routine medical equipment and supplies
8.2.1.4
Physical, speech, occupational, and respiratory therapies
8.2.1.5
Transportation
8.2.1.6
Pharmacy services
8.2.1.7
Dietitian services
8.2.1.8
Assistance with daily living skills
8.2.2
In addition, nursing facilities are responsible for the following durable medical equipment (DME), medical supplies and other items considered routine for each resident to attain and maintain the highest practicable physical and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

- Alternating pressure pads and pumps
- Analgesics (OTC)
- Antacids (OTC)
- Armboards
- Bedpans, urinals, basins
- Bedrails, beds & mattress and mattress covers
- Blood glucose monitors and
- supplies
- Canes

- Commodes
- Compressors
- Crutches
- Denture cups
- Dialysis & maintenance
- Dressing items (applicators, tongue blades, tape, gauze, bandages, bandaids, pads and compresses, elasticized ace bandages, petroleum jelly vaseline gauze, cotton balls, slings, triangle bandages, pressure pads, and tracheostomy care kits)
- Emesis basins, bath basins
- Enemas and enema equipment
- Extra nursing care and supplies
- Facial tissues & toilet paper
- First aid type ointments
- Footboards
- Foot cradles
- Gel pads or cushion (example:
- Action Cushion)
- Geriatric Geri-chairs
- Gloves, rubber or plastic
- Gradient compression stockings
- Heating pads
- Heat lamps, examination light
- Humidifiers, concentrators and canisters, and stands
- Ice bags, hot water bottles
- Intermittent Positive
- Pressure Breathing (IPPB) machines
- Irrigation solution (H2O, normal saline)
- I.V. stands, clamps, and tubing
- Laundry (including personal laundry)
- Laxatives
- Lifts
- Lotions, creams and powders
- Maintenance care for residents who have head injuries
- Mouthwash
- Nebulizers
- Nutritional supplements
- Orthotics and splints to prevent or correct contractures
- Ostomy supplies
- Oxygen, masks, stands, tubing,
- regulators, hoses, catheters, cannulas and humidifiers
- Parenteral, enteral infusion pumps
- Patient gowns, pajamas, bed linens
- Restraints
- Sheepskins, foam pads
- Skin antiseptic
- Sphygmomanometer,
- stethoscopes, & other examination equipment
- Stool softeners
- Stretchers
- Suction pumps and tubing
- Syringes & needles (except insulin
- syringes & needles for diabetics that are covered by pharmacy program)
- Therapy (occupational speech,
- physical, respiratory)
- Thermometers
- Total nutritional replacement therapy
- Traction apparatus & equipment
- Transportation (non-emergent)
- Underpads & adult diapers
- (disposable/non-disp.)
- Urinary supplies, urinary catheters and accessories
- Vitamins (OTC)
- Walkers
- Water pitchers, glasses, straws
- Weighing scales
- Wheelchairs

8.2.3
The CONTRACTOR(S) shall adhere to all policies and requirements stipulated in the Nursing/Intermediate Care Facility Provider Manual https://www.kmap-state-ks.us/public/providermanuals.asp and the following Kansas Administrative Regulations:
8.2.3.1
30-10-1a. Nursing facility program definitions.
8.2.3.2
30-10-1b. Nursing facility program providers
8.2.3.3
30-10-1c. Provider agreement.
8.2.3.4
30-10-1d. Inadequate care.
8.2.3.5
30-10-1f. Private pay wings.
8.2.3.6
30-10-2. Standards for participation; nursing facilities and nursing facilities for mental health.
8.2.3.7
30-10-6. Admission procedure.
8.2.3.8
30-10-7. Screening, evaluation, reevaluation, and referral for nursing facilities.
8.2.3.9
30-10-11. Personal needs fund.
8.2.3.10
30-10-19. Rates; effective dates.
8.2.3.11
30-10-20. Payment of claims.
8.2.3.12
30-10-23c. Revenues.
8.2.3.13
30-10-24. Compensation of owners, related parties, and administrators.
8.2.3.14
30-10-21. Reserve days.
8.2.3.15
30-10-28. Resident days.
8.2.3.16
129-10-15a. Reimbursement.
8.2.3.17
129-10-15b. Financial data.
8.2.3.18
129-10-26. Interest expense.
8.2.3.19
129-10-17. Cost reports.
8.2.3.20
129-10-18. Rates of reimbursement.
8.2.3.21
129-10-23a. Nonreimbursable costs.
8.2.3.22
129 10 23b. Costs allowed with limitations.
8.2.3.23
129-10-25. Real and personal property fee.
8.2.3.24
129-10-27. Central office costs.