CONTRACT
Between
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
AND
SUNFLOWER STATE HEALTH PLAN, INC.
for
Managed Care for Medicaid and CHIP Programs (KanCare)

This Contract is made and entered into by and between the Kansas Department of Health and Environment, whose address is 900 S.W. Jackson, Rm. 900N, Topeka, Kansas, 66612, hereinafter referred to as "the State" and Sunflower State Health Plan, Inc., whose address is 534 South Kansas Avenue, Suite 305, Topeka, Kansas 66603, hereinafter referred to as "Contractor."

KDHE, pursuant to Executive Reorganization Order No. 38, became the successor to the Kansas Health Policy Authority (KHPA) effective July 1, 2011. The successor can exercise any contractual authority granted to KHPA.

KDHE is authorized by K.S.A. 2007 Supp. 75-7401 et seq., to enter into a Contract to obtain managed care for the Kansas Medicaid and CHIP programs. Services included in this Contract are physical health services, behavioral health services, and long term care (LTC), including nursing facility (NF) care and home and community based services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services;

The Contractor is a recognized provider of these services and desires to provide them to the State; and

a Request for Proposal (RFP), #0001028, was issued on November 8, 2011 pursuant to K.S.A. 75-37,102 for acquisition of these services; and

a Procurement Negotiating Committee (PNC) conducted negotiations and determined the best interests of the State will be served by awarding a Contract to Contractor to provide such services.

NOW, THEREFORE, for and in consideration of the mutual covenants and agreement contained herein, the State and Contractor do hereby mutually covenant and agree as follows, provided that any provisions below are intended to be in addition to and to supplement the provisions contained in the RFP, the Contractor's proposal, and any amendments and responses to those documents as specified in Section III.c.-e. below, unless the provision in this document expressly states that it is to replace a provision in one or more of the documents specified in Section III.c.-e. below:

I. NO LAPSE FOR SUCCESSOR TO KDOA AND SRS:

Pursuant to Executive Reorganization Order No. 41 (ERO 41), the Kansas Department on Aging (KDOA) will become the Kansas Department for Aging and Disability Services (KDADS), and the Kansas Department on Social and Rehabilitation Services (SRS) will become the Kansas Department for Children and Families (DCF), both effective July 1, 2012. This agreement, while executed before

this effective date, will continue in effect. The successor can exercise any contractual authority granted to KDOA. As also set forth in ERO 41, certain functions and responsibilities previously assigned to SRS will be reassigned to KDADS, with the remaining functions assigned to DCF. Any references to KDOA in the RFP or any subsequent questions or responses are hereby amended to reference KDADS. In addition, any references to SRS agency functions or responsibilities transferred to KDADS under ERO 41 are hereby amended to reference KDADS. Finally, any references to SRS agency functions or responsibilities that are not being transferred to KDADS under ERO 41 are also hereby amended to reference DCF.

II. SCOPE OF WORK:

As required in the Contract documents specified in Section 3 below, Contractor will provide the State with managed care services for the Medicaid and CHIP programs. Services included are physical health service, behavioral health services and Long Term Care (TLC), including nursing facility (NF) care, mental health nursing facility care for members age 21 and under and age 65 and older, and home and community based services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services including existing 1915 c HCBS Waiver programs for children with a Serious Emotional Disturbance (SED). The Contractor agrees to furnish all the services and items in accordance with the bid specifications of RFP #0001028 and all amendments.

III. CONTRACT DOCUMENTS:

The Contract documents shall consist of the following documents. In the event of conflict of terms of language among the documents, the following order of precedence shall govern:

a. Form DA-146A;
b. Written modification to the executed Contract;
c. Written Contract signed by the parties;
d. Request for Proposal #0001028, including all attachments and exhibits, and Amendments 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13;
e. Contractor's written proposal submitted in response to the Request for Proposal as finalized, including;
   1) Original Technical, revised Technical and final Cost Proposal submitted by Contractor, dated January 31, 2012, February 22, 2012 and May 22, 2012 respectively.
   2) Contractor's written responses to State's questions/assurances.
   3) State's written responses to Contractors questions.

IV. CONTRACT PERIOD:

This Contract shall commence beginning January 1, 2013 through December 31, 2015 (the "Initial Term"), with two one (1) year renewal periods exercisable at the option of the State (each a "Renewal Term"). The State shall notify the Contractor in writing of its intent to exercise its option to renew at least six months prior to the end

of the Initial Term or the first Renewal Term. The Contractor will respond to the state within 30 calendar days of receipt of notice of State's intent.

V. CENTERS FOR MEDICARE AND MEDICAID FEDERAL REQUIREMENTS:

The following sections are added to the RFP to meet federal requirements as set forth by the Centers for Medicare and Medicaid Services (CMS):

a. 2.2.8.2.6

Any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, is permitted to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.

b. 2.2.8.3.1

CONTRACTOR(S) shall demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers.

c. 2.2.8.11.2.1

The CONTRACTOR(S) may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition.

d. Section 2.2.13.11 is amended to read:

Such value-added services may include anything permissible under applicable Federal Medicaid and CHIP regulations, including incentives offered to promote preventive services exempted in the HHS OIG Special Advisory Bulletin located at http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf and may include, but will not be limited to:

e. 2.2.25.1.1.4

Timeframes for notice of action: Termination, suspension or reduction of services - MCO or PIHP gives notice by the date of the action for the following:

f. 2.2.25.1.1.4.1

an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or

g. 2.2.25.1.1.4.2

the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

h. 2.2.38.2.7

The requirements found in Section 2.2.38.2 and its subsection, shall also apply to all participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider in each CONTRACTOR'S network.

i. 2.2.40.7.1

The contractor must define service authorization in a manner that at least includes a managed care enrollee's request for the provision of a service.

j. 2.3.3.1.1.13

A recipient may request disenrollment without cause at the following times:

k. 2.3.3.1.1.13.1

Upon automatic reenrollment under 42 CFR 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

l. 2.3.3.1.1.13.2

When the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(3).

m. Section 2.3.6.8 is amended to read:

Inpatient hospitals and nursing facilities are entitled to three (3) reasonable offers at or above the FFS rates unless another payment structure is negotiated. If they do not CONTRACT with the MCO, out of network providers will receive 90% of FFS rates. This payment requirement also applies to services provided under the prudent layperson definition of emergency services.

n. 2.3.6.10

CONTRACTOR(S) shall insure that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

VI. PAY FOR PERFORMANCE MEASURES:

The State will work collaboratively with all three of the MCO Contractors collectively, and provide policy guidance and program direction, in a good faith effort to ensure that all Pay for Performance (PFP) measures are clearly understood; that all PFP measures are consistently defined; that the necessary data to evaluate the PFP measurements are identified and accessible (including through the establishment of selected targeted interfaces and/or supplemental data exchange efforts by the contractors); and that every concern or consideration from the three successful bidders is heard. When that process is completed, as determined by the State, the final details as to each measure will be communicated and will be binding upon each contractor.

Those measures that are built upon existing practices (such as the mental health/substance use disorder NOMS) will have some variability in terms of improvement required, none of which will be over 5% per year but some of which will be considerably under 5% each year. Those detailed sub-measure requirements will likewise be developed collaboratively between the State, the successful bidders, and with targeted input from other stakeholders. When that process is completed, as determined by the State, the final details as to each measure will be communicated and will be binding upon each contractor.

Those measures which relate specifically to services covered in the I/DD HCBS waiver (such as increased competitive employment for people using those services), as determined by the State after Contractor input, will have an additional year of benchmarking during year two of the program, and will be treated as presumptively met for year two. (This additional year for benchmarking and presumptively met status would only apply to those measures specifically identified by the State; all other measures, and portions of measures that apply also to programs other than the I/DD HCBS waiver, will remain in effect and the State will expect vendors to comply with the performance requirements.

VII. STANDARIZATION OF PROCESSES:

The Contractor agrees to standardization of work processes between the State and all KanCare providers to provide the most efficient implementation and management of the KanCare Program.

Processes to be included, but are not limited to, are as follows:

a. Provider credentialing (forms, criteria, and processing)

b. Credentialing Requirements for Pharmacists to provide Medical Therapy Management (MTM)

c. Pharmacy Website Information (Prior Authorization criteria/forms, Provider Manual, Preferred Drug List information, Pricing Lookup, etc.)

d. Authorization procedures for services

e. Claims billing processes

f. Provider network documentation

g. Provider surveys

h. Operations, quality, customer service, and grievance report formats

VIII. REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS:

The Contractor agrees the reimbursement floor for federally recognized Critical Access Hospitals (CAHs), as the state fee-for-service Diagnostic-Related Group (DRG) payment schedule for inpatient service and the fee schedule for outpatient services, as established by the State in its sole discretion from time to time, plus an adjustment using a Cost Adjustment Factor as established by the State on an annual basis. The adjustment may be a tiered or hospital-specific factor, or a similar methodology. CAHs will be reimbursed no less than 100 percent of the reimbursement floor as defined in this paragraph.

IX. CAPITATION RATES:

The capitation plan rates for the first year of the contract are based on the Contractors Low Cost Estimate (LCE) discount submission of May 22, 2012 (Attachment A). Plan discounts for 2nd and 3rd year of the base year's contract will be based on the Contractors LCE submission of April 18, 2012 (Attachment B). The rates for the first year as attached will become effective upon the date of CMS approval

The State will notify the Contractor of rate adjustments for the 2nd and 3rd years in September 2013 and September 2014, respectively. Contractors will have 30 calendar days from the date of the notification to review and comment prior to submission to CMS.

X. PHARMACY

A. Medication Therapy Management

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

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

iii. Contractor agrees that the listed MTM services must be reviewed both at the patient's initial MTM encounter and in subsequent Complete Drug Reviews that will occur as needed and on an annual basis.

iv. The Contractor agrees to standardization between the State and all KanCare providers of the credentialing requirements for pharmacists to provide MTM services.

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

vi. Contractor agrees that any willing contracted pharmacy provider who meets the MCO standardized credentialing requirements will be allowed to provide MTM services.

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

viii. The Contractor agrees that MTM services are to be provided on a face-to-face patient/pharmacist basis, and that these services shall be provided by a licensed Kansas pharmacist who is also MCO-credentialed.

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

B. Pharmacy PDL and DUR Processes

i. Kansas law permits the State to restrict access to prescription drugs through the use of a program of prior authorization or restrictive formulary only as established by duly adopted regulation. K.S.A. § 39-7,120(a). The State has done this by promulgating a list of drugs for which prior authorization (PA) will be required at K.A.R. § 129-5-1(b).

ii. Contractor understands and agrees there will be one Preferred Drug List (PDL) under KanCare. Contractor will submit criteria for prior authorization for a given drug to be reviewed by the state's Drug Utilization Review Board (DUR), per state statute. Upon approval by the DUR Board, state staff will be responsible for appearing before the Joint Committee on

Administrative Rules and Regulations for the purpose of adding drugs to K.A.R. § 129-5-1(b).

C. Pharmacy Mail Order

i. Contractor agrees that although they may offer mail order pharmacy as an option to beneficiaries, they or their Pharmacy Benefits Manager(PBM) are not allowed to require or incentivize the use of Mail Order Pharmacy, including through differential patient co pays.

D. Pharmacy Dispensing Fee

i. Contractor agrees to the reimburse pharmacy providers at or above the rate of the state-mandated pharmacy dispensing fee. As of contract date, this rate is $3.40 per claim.

E. Specialty Pharmacy

i. Contractor agrees that while specialty pharmacy options can be made available to the patient, the Contractor may not require beneficiaries to receive medications from a specialty pharmacy program.

F. Pharmacy Benefit Manager

i. Contractor agrees their contracted PBM will be directly available to State staff and oversight regarding provider concerns and issues, as well as other oversight the State deems appropriate.

G. Pharmacy Reimbursement

i. Contractor agrees that pharmacies will be reimbursed at a rate comparable to current (12/31/2012) fee-for-service reimbursement.

H. Maximum Allowable Cost List Administration

Contractor agrees that it or its PBM will:

i. On or before January 1 of each contract year, notify contracting pharmacies the basis of the methodology and sources utilized to determine the Maximum Allowable Cost (MAC) pricing of the PBM;
ii. Update MAC pricing information regularly;
iii. Make MAC pricing information available directly or by active link from a central KanCare website;
iv. Establish a process for the timely notification of the MAC pricing updates to network pharmacies;
v. Eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace;
vi. Provide a reasonable administrative appeals procedure to allow a dispensing provider to contest a listed MAC rate that includes the

following:

a. The PBM must respond to a provider who has contested a MAC rate through this procedure within 30 calendar days;
b. If an update is warranted, the PBM shall make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network.

XI. THIRD PARTY LIABILITY SUPPLEMENTAL RECOVERY:

The State reserves the right to conduct a supplemental (come-behind) recovery program for Third Party Liability (TPL). Any TPL identified and recovered by the State more than 6 months after the date of payment of a claim will be retained by the State.

XII. SPENDDOWN: The State and the Contractor agree that the capitated rates associated with this Contract reflect all costs associated with the medically needy aged and disabled ("spenddown") populations net of shared cost. The enrollment process described below is consistent with the rate development methodology used.

Notification: The state will assign beneficiaries in the spenddown population immediately to Contractor using the regular enrollment file process.

Payment: The State will pay a capitated rate for each member of the spenddown population assigned to the Contractor's plan starting with the first month of assignment. Contractor is responsible for the provision of services to the spenddown member from the date of the assignment. Contractor is also responsible for monitoring the status of the member's spenddown, paying claims only after the spenddown has been met and keeping track of the claims not paid and applied to the member's spenddown. Contractor must identify which claims were use to meet each member's spenddown and provide that information to the State at an agreed-upon time.

XIII. RETROSPECTIVE CAPITATION PAYMENTS:

The State will make retrospective payments to Contractor for enrolled members no later than the third business day after the first Friday of the following month. For example, the State would make January 2013 capitation payments no later than Wednesday, February 6, 2013.

XIV. HEALTH HOME:

The State intends to allow as much innovation as possible with all KanCare MCO providers in the Health Home program. Should CMS mandate all the KanCare MCO's be required to conform to a single payment structure for Health Homes across all MCO's, the contractor agrees to comply with a single payment structure for Health Homes.

XV. INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATIONS:

Indian Health Service, tribal and urban Indian organization programs will be eligible for participation in federal health programs to the same extent as any other provider. There will be no barrier to tribal members accessing any Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) and I/T/U providers will be reimbursed at no less than current reimbursement.

The State and the Contractor agree other protections for tribal members and I/T/U providers (including Indian Health Services and 638 clinics) will continue. These protections include, but are not limited, to the following:

a. No Medicaid premiums or cost sharing for tribal members;

b. Exemptions for Indians who have used an I/T/U or are eligible to use an I/T/U, including contract health service (CHS);

c. I/T/U and CHS provider payments may not be reduced by the amount of the cost sharing;

d. Exemption of certain Indian-specific property from consideration in determining eligibility for Medicaid, as under ARRA Section 5005(b); and

e. Exemption from Medicaid Estate Recovery Act rules, as per ARRA Section 5006(c).

And specific to managed care, the Contractor will:

f. Permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;

g. Provide sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;

h. Agree that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

i. Provide that prompt payments will be made to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR 447.45 and 447.46

XVI. DELAY OF FUNDING FOR HCBS SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES:

The 2012 Kansas legislature expressly restricted the use of State funding for the provision of home and community based services (HCBS) for individuals with intellectual and developmental disabilities or targeted case management for individuals with intellectual and developmental disabilities under any managed care system or under managed care oversight. Accordingly, Contractor agrees that its provision of HCBS services for individuals with intellectual and developmental disabilities will be delayed until January 1, 2014. On and after that date, Contractor agrees to be prepared to provide HCBS services to individuals with developmental disabilities as provided in Contractor's RFP responses. Contractor acknowledges and agrees that it will begin providing physical and behavioral health services for individuals with developmental disabilities on the same date as non-disabled members, specifically, January 1, 2013.

During the period of January 1 to December 31, 2013, Contractor further agrees to work with the State on the development of pilot programs for the demonstration, testing and evaluation of the delivery of services through the home and community based waiver for individuals with developmental disabilities or targeted case management for individuals with developmental disabilities.

Contractor agrees that the LCE bids referenced in Section IX above are accurate in light of the delay in provision of HCBS services to the developmentally disabled population. .

XVII. FRAUD ENFORCEMENT BY STATE ATTORNEY GENERAL:

Contractor acknowledges and agrees that the Kansas Medicaid Fraud Control Unit (MFCU), which is part of the Kansas Attorney General's office, will have the right to recover fraudulent Medicaid payments directly from participating and non-participating providers and subcontractors of Contractor, and from any other third parties in Contractor's provider network. Contractor acknowledges and agrees that it is not entitled to any portion of any recovery by the Kansas MFCU. Further, Contractor agrees to be subrogated to the State for any and all claims Contractor has or may have against pharmaceutical companies, retailers, providers, or other subcontractors, medical device manufacturers, or durable medical equipment manufacturers in the marketing and pricing of their products.

XVIII. PAYMENT:

Section 2.3.6.2 of the RFP is hereby amended to add the following sentence to the end of that Section: "Subject to the provisions of (a) this Section 2.3.6.2 above regarding performance withholds, and (b) Section 2.3.6.3 and its subsections, capitation payments made by the State to Contractor constitute full and complete payment to Contractor for all goods and services provided by Contractor to the State for the time period covered by such capitation payments."

XIX. CORRECTION OF CONTRACT YEAR REFERENCE:

Every reference in the RFP to "Contract Year 2012" is hereby changed to "Contract Year 2013."

XX. FINAL CONTRACT APPROVAL:

CMS must review and approve this Contract once it is signed by all parties. The contract will not be considered final until the State receives CMS approval.

However, the Contractor will begin development of the Contractor's MCO program prior to final CMS approval. Should CMS for any reason not approve the Contract as submitted; the State will not be held liable for any expenses incurred by the Contractor up to the date of disapproval of the Contract by CMS.

XXI. PROVIDER MANUAL UPDATES AND COMMUNICATIONS:

Contractor agrees to notify Providers of changes to the Provider Manual by written notification in the form of, but not limited to, letters, memorandum, provider newsletters and bulletins. Contract agrees to post program changes of any kind on the Contractor's website and the Contractor's provider portal.

Contractor agrees to notify Providers at least 30 days prior to the effective date of changes to the Provider Manual.

XXII. UTILIZATION MANAGEMENT:

Contractor will be transparent regarding all utilization management criteria it applies to any service, consistent with RFP section 2.2.40. This information will not be treated as proprietary and will be available broadly, including but not only on the Contractor's website, directly or by active link.

XXIII. NURSING FACILITIES FOR MENTAL HEALTH:

The State clarifies that nursing facilities for mental health is a covered service for members age 21 and under and age 65 and older.

XXIV. MODIFICATIONS:

This Contract shall only be modified by the mutual, written agreement of the parties.

XXV. OWNERSHIP

Section 4.1.1.50 of the RFP, "Ownership," is hereby amended to read as follows:

All data, forms, procedures, software, manuals, system descriptions, or set of systems rules, source code, and workflows developed by the Contractor during the term of this Contract for use under this Contract will be owned by and are the property of the State. The Contractor may not release any such materials without the written approval of the State. Software, data, processes and programs that are owned by, proprietary to, or licensed by the Contractor as of the effective date of

this Contract, or that are developed by the Contractor outside the scope of this Contract, will be owned by and are the property of the Contractor.

XXVI. FINANCIAL REPORTING:

The following Sections of the RFP are hereby amended to read as follows:

a. 2.2.28.4

The Contractor shall file with the State, a *Quarterly Financial Report.* These reports shall be on the form prescribed by the NAIC for health maintenance organizations and shall be submitted to the State on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year), and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the Contractor's quarterly and year-to-date revenues earned and expenses incurred as a result of the Contractor's participation in the KanCare program. The second quarterly report (submitted on August 15) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with NAIC guidelines. The Contractor shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

b. 2.3.4.4

The Contractor, the Contractor's parent company, and all non-provider subcontractors that are not affiliated with Contractor will provide the results of an annual audit performed by an independent Certified Public Accountant and to authorize the Contractor to share this information with the State. The Contractor shall authorize the independent accountant to allow representatives of the State, upon written request, to verify the audit report.

c. Parent Company Guarantee

In addition, the form Parent Company Guarantee (as provided during vendor negotiations), is hereby deleted in its entirety and replaced with the form Parent Company Guarantee attached hereto as Attachment 1.

XXVII. PRIOR PERIOD OF COVERAGE:

When developing rates for KanCare, the State included prior period of coverage.

The State and Contractor agree to monitor prior period of coverage experience; and the State will consider rate adjustments if Contractors actual prior period of coverage experience is materially different than assumed in KanCare rate development.

IN WITNESS HEREOF, the parties hereto have caused this instrument to be executed by their duly authorized official or officers this 27th day of June, 2012.

SUNFLOWER STATE HEALTH PLAN

By: _____

Printed Name: JESSE HUNTER

Title: VICE PRESIDENT

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

By: _____

Printed Name: Robert Moser MD

Title: Secretary

I hereby certify that the competitive bid/procurement laws of the State of Kansas have been followed:

State of Kansas

By: _____ 6/27/12

Chris Howe, Director
Procurement and Contracts

ATTACHMENT A

State of Kansas
Department of Administration
DA-146a (Rev. 10-11)

CONTRACTUAL PROVISIONS ATTACHMENT

Important: This form contains mandatory contract provisions and must be attached to or incorporated in all copies of any contractual agreement. If it is attached to the vendor/contractor's standard contract form, then that form must be altered to contain the following provision:

"The Provisions found in Contractual Provisions Attachment (Form DA-146a, Rev. 10-11), which is attached hereto, are hereby incorporated in this contract and made a part thereof."

The parties agree that the following provisions are hereby incorporated into the contract to which it is attached and made a part thereof, said contract being the _____ day of _____, 20_____.

1. **Terms Herein Controlling Provisions**: It is expressly agreed that the terms of each and every provision in this attachment shall prevail and control over the terms of any other conflicting provision in any other document relating to and a part of the contract in which this attachment is incorporated. Any terms that conflict or could be interpreted to conflict with this attachment are nullified.

2. **Kansas Law and Venue**: This contract shall be subject to, governed by, and construed according to the laws of the State of Kansas, and jurisdiction and venue of any suit in connection with this contract shall reside only in courts located in the State of Kansas.

3. **Termination Due To Lack Of Funding Appropriation**: If, in the judgment of the Director of Accounts and Reports, Department of Administration, sufficient funds are not appropriated to continue the function performed in this agreement and for the payment of the charges hereunder, State may terminate this agreement at the end of its current fiscal year. State agrees to give written notice of termination to contractor at least 30 days prior to the end of its current fiscal year, and shall give such notice for a greater period prior to the end of such fiscal year as may be provided in this contract, except that such notice shall not be required prior to 90 days before the end of such fiscal year. Contractor shall have the right, at the end of such fiscal year, to take possession of any equipment provided State under the contract. State will pay to the contractor all regular contractual payments incurred through the end of such fiscal year, plus contractual charges incidental to the return of any such equipment. Upon termination of the agreement by State, title to any such equipment shall revert to contractor at the end of the State's current fiscal year. The termination of the contract pursuant to this paragraph shall not cause any penalty to be charged to the agency or the contractor.

4. **Disclaimer Of Liability**: No provision of this contract will be given effect that attempts to require the State of Kansas or its agencies to defend, hold harmless, or indemnify any contractor or third party for any acts or omissions. The liability of the State of Kansas is defined under the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.).

5. **Anti-Discrimination Clause**: The contractor agrees: (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq.) and the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111 et seq.) and the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101 et seq.) (ADA) and to not discriminate against any person because of race, religion, color, sex, disability, national origin or ancestry, or age in the admission or access to, or treatment or employment in, its programs or activities; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if the contractor is found guilty of any violation of such acts by the Kansas Human Rights Commission, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration; (f) if it is determined that the contractor has violated applicable provisions of ADA, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration.

   Contractor agrees to comply with all applicable state and federal anti-discrimination laws.

   The provisions of this paragraph number 5 (with the exception of those provisions relating to the ADA) are not applicable to a contractor who employs fewer than four employees during the term of such contract or whose contracts with the contracting State agency cumulatively total $5,000 or less during the fiscal year of such agency.

6. **Acceptance Of Contract**: This contract shall not be considered accepted, approved or otherwise effective until the statutorily required approvals and certifications have been given.

7. **Arbitration, Damages, Warranties**: Notwithstanding any language to the contrary, no interpretation of this contract shall find that the State or its agencies have agreed to binding arbitration, or the payment of damages or penalties. Further, the State of Kansas and its agencies do not agree to pay attorney fees, costs, or late payment charges beyond those available under the Kansas Prompt Payment Act (K.S.A. 75-6403), and no provision will be given effect that attempts to exclude, modify, disclaim or otherwise attempt to limit any damages available to the State of Kansas or its agencies at law, including but not limited to the implied warranties of merchantability and fitness for a particular purpose.

8. **Representative's Authority To Contract**: By signing this contract, the representative of the contractor thereby represents that such person is duly authorized by the contractor to execute this contract on behalf of the contractor and that the contractor agrees to be bound by the provisions thereof.

9. **Responsibility For Taxes**: The State of Kansas and its agencies shall not be responsible for, nor indemnify a contractor for, any federal, state or local taxes which may be imposed or levied upon the subject matter of this contract.

10. **Insurance**: The State of Kansas and its agencies shall not be required to purchase any insurance against loss or damage to property or any other subject matter relating to this contract, nor shall this contract require them to establish a "self-insurance" fund to protect against any such loss or damage. Subject to the provisions of the Kansas Tort Claims Act (K.S.A. 75-6101 et seq.), the contractor shall bear the risk of any loss or damage to any property in which the contractor holds title.

11. **Information**: **No provision of this contract shall be construed as limiting the Legislative Division of Post Audit from having access to information pursuant to K.S.A. 46-1101 et seq.**

12. **The Eleventh Amendment**: "The Eleventh Amendment is an inherent and incumbent protection with the State of Kansas and need not be reserved, but prudence requires the State to reiterate that nothing related to this contract shall be deemed a waiver of the Eleventh Amendment."

13. **Campaign Contributions / Lobbying:** Funds provided through a grant award or contract shall not be given or received in exchange for the making of a campaign contribution. No part of the funds provided through this contract shall be used to influence or attempt to influence an officer or employee of any agency or a member of the Legislature regarding any pending legislation or the awarding, extension, continuation, renewal, amendment or modification of any government contract, grant, loan, or cooperative agreement.

ATTACHMENT C
Definitions & Acronyms

As used throughout this Request for Proposals, the following terms shall have the meanings set forth below unless the context clearly indicates otherwise.

A

Accept Medicaid Assignment - Means the provider will accept the Medicaid-allowed payment rate as payment in full for services provided to a recipient.

Accept Medicare Assignment - Means the provider will accept the Medicare-allowed payment rate as payment in full for services provided to a recipient.

Access - Ability of a beneficiary to receive adequate medical care with all necessary services being available and close.

Action – (Grievance Process) The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure of the health plan to act within established time requirements (provided in 42 CFR 438.408(b)) for service accessibility.

Additional Services - Health care that the MCO agrees to provide beyond the required covered services.

Administrative Services Organization - Any public or private entity this is organized primarily for the purpose of providing administrative services in support of health care services.

Admission - Means entry into a hospital for the purpose of receiving inpatient medical treatment.

Advance Directives – Means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

AIMS – A comprehensive data set of demographic, client status, and encounter data for the Mental Health consumers served by local Community Mental Health Centers (CMHCs) in Kansas.

Annual Resurvey – Annual licensure and certification surveys conducted by KDOA.

ANSI - A national organization founded to develop voluntary business standards in the United States.

Appeal **-** A request for review of an action, as action is defined in this section.

Appeal Process - The health plan's process for handling of appeals that complies with the requirements specified including, but not limited to, the procedural steps for a beneficiary to file an appeal, the process for resolution of an appeal, the right to access the State Fair Hearing system, and the timing and manner of required notifications.

Average Length of Stay – Average number of days of service provided to each nursing facility resident.

Average Nursing Facility Utilization – The average number of nursing facility days of service provided for each nursing facility eligible beneficiary.

B

Beneficiary - See "Eligible Beneficiary."

Border Cities - means those communities outside of the state of Kansas but within a 50-mile range of the state border.

C

Capitated Managed Care - Means a type of managed care plan that uses a risk-sharing reimbursement method whereby providers receive fixed periodic payments for health services rendered to plan members. Capitated fees shall be set by contract with providers and shall be paid on a per person basis regardless of the amount of services rendered or costs incurred.

Capitation - A method of payment the State makes periodically to a contractor on behalf of each recipient enrolled under the contract for the provision of medical services under the State plan.

Clean Nursing Facility Claims – Claims that do not trigger an edit for denial or suspension.

Clean claims - Claims that can be processed without obtaining additional information from the provider of the service or from a third party.

CLIA Standards - A set of standards issued by the Health Care Financing Administration (HCFA) to ensure consistency of laboratory services.

CMS - a division within the federal Department of Health and Human Services which administers Medicare and oversees the state's administration of Medicaid.

COB - Provision regulating payments to eliminate duplicate coverage when a beneficiary is covered by multiple group plans.

Community Service Providers – Means a community developmental disability organization or affiliate thereof.

Consultant - Any corporation, company, organization or person or their affiliates retained by the State to provide assistance in this project or any other project, not the MCO or subcontractor.

Covered Services - Those services which the MCO is required to provide under this contract.

D

Day - except where the term working/business day is expressly used, all references to “days” in this contract shall be construed as calendar days.

Disenrollment - the removal of a member from the MCO’s roster which results in a cessation of services for that member.

Drug, supply, or device - means the following:

(1) Any article recognized in the official United States pharmacopoeia, another similar official compendium of the United States, an official national formulary, or any supplement of any of these publications;
(2) any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings; and
(3) any article intended to affect the structure or any function of the bodies of human beings; and
(4) any article intended for use as a component of any article specified in paragraphs a., b., or c. above.

Durable medical equipment or DME - Means equipment that meets these conditions:

(1) Withstands repeated use;

(2) is not generally useful to a person in the absence of an illness or injury;
(3) is primarily and customarily used to serve a medical purpose;
(4) is appropriate for use in the home; and
(5) is rented or purchased as determined by the State.

E

Eligible Beneficiary or Beneficiary - A person who receives Title XIX coverage in accordance with the Medicaid State Plan or who receives Title XXI coverage.

Eligible Provider or Provider - A health care provider enrolled with the MCO to provide health care services to Title XIX and Title XXI recipients.

Emergency Medical Condition - Means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

Emergency Services: - Means covered inpatient and outpatient services that are as follows:
(1) Furnished by a provider that is qualified to furnish these services.
(2) Needed to evaluate or stabilize an emergency medical condition.

Emergent Primary Care Services - Those services provided in a physician's office or minor emergency center in response to an emergency (e.g., high temperature, persistent vomiting or diarrhea, or symptoms which are of a sudden or severe onset but which do not require emergency room services).

Encounter - When a member receives services from a given health care provider.

Enrollment - The assignment of a beneficiary or eligible beneficiary eligible into a MCO.

Enrollment Area - the geographic area within which eligible beneficiaries/beneficiaries must reside in order to enroll in the MCO under this contract.

EPSDT - A program of preventive health care, well child examinations with appropriate tests and immunizations. It is called the KAN Be Healthy Program in Kansas.

F

Fair Hearing - A formal meeting where an impartial Hearings Officer, assigned through the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.

Federally Qualified MCO - An MCO which has received special designation by CMS, to allow a minimum enrollment guarantee provision.

Fee-For-Service - The payment method by which the State reimburses providers for each medical service rendered to a patient.

Formulary - means a listing of drugs, supplies, or devices

FQHC - An entity that has entered into an agreement with CMS and is receiving a grant or funding from a grant under Section 329, 330, or 340 of the Public Health Service Act.

Fraud - intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal and state laws and regulations.

G

Grievance - An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Grievance Process **-** The health plan process for handling of grievances that complies with the requirements including, but not limited to, the procedural steps for a member to file a grievance, the process for disposition of a grievance, and the timing and manner of required notifications.

Grievance System **–** Each MCO and PIHP must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's Fair Hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process.

H

HCBS – Home and community based services provided through multiple 1915(c) waivers.

Hospital Readmission - Means the subsequent admission of a member as an inpatient into a hospital within 30 days of discharge as an inpatient from the same (transfers from an acute care bed to a psychiatric bed in the same hospital or transfers between hospitals are not considered readmissions).

I

Indian Health Clinic - There are three types of Indian Health Clinics:
(1) Indian Health Services clinic (abbreviation AI'): These are operated by Indian Health Services.
(2) 638 Clinic (abbreviation AT'): These are operated by the Tribes according to Public Law 93-638.
(3) Indian Urban Health Clinic (abbreviation AU'): These clinics are operated with a Provider type under Title V Public Law, 94-437.

Inquiry - A request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction.

K

KAN Be Healthy - The name of the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program in Kansas.

Kan Be Healthy program participant - Means an individual under the age of 21 who is eligible for Medicaid, and who has undergone a Kan Be Healthy medical screening in accordance with a specified screening schedule. The medical screening shall be performed for the following purposes:
(1) To ascertain physical and mental defects; and
(2) to provide treatment that corrects or ameliorates defects and chronic conditions that are found.

Kan Be Healthy dental-only participant - Means an individual under the age of 21 who is eligible for Medicaid, and has undergone only a Kan Be Healthy dental screening in accordance with a specified screening schedule. The dental screening shall be performed for the following purposes:
(1) To ascertain dental defects; and

(2) to provide treatment that corrects or ameliorates dental defects and chronic dental conditions that are found.

Kan Be Healthy vision-only participant - Means an individual under the age of 21 who is eligible for Medicaid, and who has undergone only a Kan Be Healthy vision screening in accordance with a specified screening schedule. The vision screening shall be performed for the following purposes:
(1) Ascertain vision defects; and
(2) provide treatment that corrects or ameliorates vision defects and chronic vision conditions that are found.

KCPC – Means the Kansas-based criteria established using the American Society of Addiction Medicine Criteria as a basis for determining the level of treatment a Member needs.

KCPC Screening Inventory – Means the standardized, computer-based assessment tool which gathers BioPsychoSocial information for a Member utilizing criteria established by the American Society of Addiction Medicine for determining the level of treatment a Member needs.

Key Personnel - The MCO's Chief Executive Officer and other MCO officers as designated within the RFP.

L

Lock-in - Means the restriction, through limitation of the use of the medical identification card to designated medical providers, pharmacy and/or hospitals, of a consumer's access to medical services because of abuse.

LTC – A variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time in a nursing facility.

M

Managed Care - Means a system of managing and financing health care techniques and concepts to ensure that services provided to members are necessary, efficiently provided, and appropriately priced.

MCO - As defined at 42 CFR 438.2, an MCO is either a federally qualified Health Maintenance Organization (HMO) or any other public or private entity this is organized primarily for the purpose of providing health care services, makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity, and meets the solvency standards of 42 CFR 438.116.

Medicaid - The Kansas Medical Assistance Program operated by the State under Title XIX of the Federal Social Security Act, and related State and Federal rules and regulations.

Medicaid Program Provider Manuals - Service specific documents created by the Kansas Medicaid fiscal agent to describe policies and procedures applicable to the program generally and that service specifically.

Medical Identification Card - An identification card issued by the State, upon determination of eligibility for Medicaid.

Medical necessity - means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
a. "Authority". The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.
b. "Purpose". The health intervention has the purpose of treating a medical condition.

c. "Scope". The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

d. "Evidence". The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided herein. For existing interventions, effectiveness shall be determined as provided in paragraph 67.i.

e. "Value". The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity.

f. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

g. The following definitions shall apply to these terms only as they are used in this subsection 67.;

1) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

2) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation's definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

3) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

4) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

5) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

6) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

7) "State designee" means a person or persons designated by the State to assist in the medical necessity decision-making process.

8) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

9) "Treating physician" means a physician who has personally evaluated the patient.

h. Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph 67.i.

i. The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit

expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

j. The CONTRACTOR is responsible for covering services related to the following:
   1) The prevention, diagnosis, and treatment of health impairments;
   2) The ability to achieve age-appropriate growth and development;
   3) The ability to attain, maintain or regain functional capacity.

Medical necessity in psychiatric situations - Means that there is medical documentation that indicates either of the following:
(1) The person could be harmful to himself or herself or others if not under psychiatric treatment; or
(2) the person is disoriented in time, place, or person.

Medical supplies - Means items that meet these conditions:
(1) Are not generally useful to a person in the absence of illness or injury;
(2) are prescribed by a physician; and
(3) are used in the home and certain institutional settings.

MediKan Program - A state/federal program for the indigent who are blind, aged, disabled or members of families with dependent children.

Member - A Title XIX or Title XXI beneficiary who has been certified by the State as eligible to enroll under this contract, and whose name appears on the MCO enrollment information which the State will transmit to the MCO every month in accordance with an established notification schedule.

Mental retardation - Means any significant limitation in present functioning that meets these requirements:
(1) Is manifested during the period of birth to age 18;
(2) Is characterized by significantly sub average intellectual functioning as reflected by a score of two or more standard deviations below the mean, as measured by a generally accepted, standardized, individual measure of general intellectual functioning; and
(3) Exists concurrently with deficits in adaptive behavior, including related limitations in two or more of the following areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

MMIS - The Medicaid Management Information System which processes fee-for-service claims and encounter data for managed care.

N

NF Admissions – Count of residents admitted to nursing facilities.

NF Discharges – Number of beneficiaries discharged from nursing facilities.

NF Diversion Rate – Rate at which nursing facility eligible beneficiaries are cared for in the community rather than being admitted to a nursing facility.

NF Utilization Rate – The average number per 100 of nursing facility eligible beneficiaries that receive nursing facility services.

Non-covered services - Means services for which Medicaid will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

Notice of Action - A written explanation to the provider or consumer of an action being taken.

O

Occupational therapy - Means the provision of treatment by an occupational therapist registered with the American occupational therapy association. The treatment shall meet these requirements:
(1) Be rehabilitative and restorative in nature;
(2) Be provided following physical debilitation due to acute physical trauma or physical illness; and
(3) Be prescribed by the attending physician.

Open Enrollment Period - Time during which eligible individuals may elect to enroll in or transfer between available health care programs.

Open Panel – A MCO accepting all willing providers or a primary care provider (PCP) who is accepting new Medicaid/CHIP members.

Orthotics and prosthetics - Means devices that meet these requirements:
(1) Are reasonable and necessary for treatment of an illness or injury;
(2) Are prescribed by a physician;
(3) Are necessary to replace or improve functioning of a body part; and
(4) Are provided by a trained orthotist or prosthetist.

Other developmental disability - Means a condition or illness that meets the following criteria:
(1) Is manifested before age 22;
(2) May reasonably be expected to continue indefinitely;
(3) Results in substantial limitations in any three or more of the following areas of life functioning:
    (a) Self-care;
    (b) Understanding and the use of language;
    (c) Learning and adapting;
    (d) Mobility;
    (e) Self-direction in setting goals and undertaking activities to accomplish those goals;
    (f) Living independently; or
    (g) Economic self-sufficiency; and
(4) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of extended or lifelong duration and are individually planned and coordinated.

Out of Plan Coverage - Medical care rendered to a member by a provider not affiliated with the MCO or under subcontract to the MCO.

Out-of-state provider - Means any provider that is physically located more than 50 miles beyond the border of Kansas, except those providing services to children who are wards of the secretary. The following shall be considered out-of-state providers if they are physically located beyond the border of Kansas:
(1) Nursing facilities;
(2) Intermediate care facilities;
(3) Community mental health centers;
(4) Partial hospitalization service providers; and
(5) Alcohol and drug program providers.

Outpatient treatment - Means services provided by the outpatient department of a hospital, a facility that is not under the administration of a hospital, or a physician's office.

Over-the-counter - Means any item available for purchase without a prescription order.

Owner - Means a sole proprietor, member of a partnership, or a corporate stockholder with five percent or more interest in the corporation. The term "owner" shall not include minor stockholders in publicly held corporations.

P

PAHP- Means an entity that:
(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
(2) Does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

Participating Provider - Any physician, hospital, pharmacy, optometrist, or other health care professional or facility that has entered into a professional service agreement to serve the MCO's members.

Pharmacist - Means any person duly licensed or registered to practice pharmacy by the state board of pharmacy or by the regulatory authority of the state in which the person is engaged in the practice of pharmacy.

Pharmacy - Means the premises, laboratory, area, or other place meeting these conditions:
(1) Where drugs are offered for sale, the profession of pharmacy is practiced, and prescriptions are compounded and dispensed;
(2) That has displayed upon it or within it the words “pharmacist,” “pharmaceutical chemist,” “pharmacy,” “apothecary,” “drugstore,” “druggist,” “drugs,” “drug sundries,” or any combinations of these words or words of similar import; and
(3) Where the characteristic symbols of pharmacy or the characteristic prescription sign “Rx” are exhibited. The term “premises” as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

Physical therapy - Means treatment that meets these criteria:
(1) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts;
(2) Is rehabilitative and restorative in nature;
(3) Is provided following physical debilitation due to acute physical trauma or physical illness; and
(4) Is prescribed by the attending physician.

Physician extender - Means a person registered as a physician’s assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided, and who is working under supervision as required by law or administrative regulation.

PIHP- Means an entity that:
(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

Potential Enrollee - Means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

Practitioner - Means any person licensed to practice medicine and surgery, dentistry, or podiatry, or any other person licensed, registered, or otherwise authorized by law to administer, prescribe, and use prescription-only drugs in the course of professional practice.

Prescribed - Means the issuance of a prescription order by a practitioner.

Prescription - Means either of the following:
(1) A prescription order; or
(2) A prescription medication.

Prescription medication - Means any drug, supply, or device that is dispensed according to a prescription order. If indicated by the context, the term "prescription medication" may include the label and container of the drug, supply, or device.

Prescription-only - Means an item available for purchase only with a prescription order.

Preventive Care - Health care that emphasizes prevention, early detection and early treatment.

Primary diagnosis - Means the most significant diagnosis related to the services rendered

Prior Authorization - Approval granted for payment purposes by the MCO for its active, specified enrollees by the State (or it's designee) to a provider to render specified services to a specified beneficiary.

Provide –To furnish directly, or authorize and pay for the furnishing of, a covered service to an enrolled beneficiary.

PRTF – An inpatient treatment facility that provides comprehensive mental health treatment to children and adolescents.

Prudent lay person – A person who possesses an average knowledge about health, healthcare and medicine.

R

Reasonable Effort –Documentation of verbal and written contacts with providers of health care services outside the MCO.

Regulation - A federal or state agency statement of general applicability designed to implement or interpret law, policy or procedure.

Reinsurance - insurance purchased by an insurance company or health plan from another insurance company to protect against losses. Also called stop-loss insurance.

RHC - An entity that has been determined by CMS to meet the requirements of Section 1861 (aa)(2) of the Social Security Act and 42 Code of Federal Regulations part 491; and has an agreement with CMS to provide rural health clinic services under Medicare.

Risk - The possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the State.

S

Self-Direction – Means that participants, or their representatives, if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services such as an agency delivery model. It allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process. Promotes personal choice and control over the delivery of waiver and State plan services, including who provides the services and how services are provided.

Shelter – Homeless shelters are temporary residences for homeless people which seek to protect vulnerable populations from the often devastating effects of homelessness while simultaneously reducing the environmental impact on the community.

SP – Plan approved by CMS governing the Kansas Medicaid Program.

SSMA – KDHE, which is legally authorized and responsible for administering the provisions of the State Plan for Medical Assistance (Medicaid) on a statewide basis.

Start Date - The date the contract for services becomes effective.

State Fiscal Year - The annual period used by the State for accounting purposes, which begins July 1 and ends June 30 of the following calendar year. (Note: the Federal fiscal year begins October 1 and ends September 30 of the following calendar year).

Subcontract - Any written agreement between the MCO and another party to fulfill the requirements of this contract.

Subcontractor - Party contracting with the MCO to perform services under this agreement.

Subrogation - procedure where an insurance company recovers from a third party when the action resulting in medical expense (e.g. auto accident) was the fault of another person.

T

Third-Party - Any individual entity or program which is or may be liable to pay all or part of the expenditures for Title XIX beneficiaries furnished under a State Plan.

Title XIX - The provisions of Title 42 United States Code Annotated Section 1396 et. seq. (The Social Security Act), including any amendments thereto. Title XIX provides medical assistance for certain individuals and families with low incomes and resources.

Title XXI - The provisions of the Social Security Act as amended in August, 1997 to add Title XXI (known at the federal level as the Children's Health Insurance Program (CHIP), which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

Transportation - A covered service available for the purpose of transporting a beneficiary to a health facility or health practitioner providing covered services under this RFP and it's resulting contract(s).

U

Urgent Primary Care Services - Those services provided in a physician's office in response to persistent rash, recurring high grade temperature, non-specific pain or fever.

Urgent Services - Covered services required in order to prevent a serious deterioration of a member's health that results from unforeseen illness or an injury.

Utilization Management - Evaluation of necessity and appropriateness of health care services according to set guidelines.

Utilization Report - A report that provides information regarding evaluation of necessity and appropriateness of health care services according to set guidelines.

V

Valid NF Claims – Claims for Medicaid approved nursing facility resident days.

W

Waiver – Federally approved requests to waive certain specified Medicaid rules.

Warm Transfer – A listening phone line staffed by people usually in recovery. Warm transfer operators are trained to listen to anonymous callers, offer compassion and validation, and assist callers in connecting with their own internal resources and strengths, as well as community resources.

Wellness - Preventive health care designed to reduce health care utilization and costs.

Acronym	Definition
A	
AAA	Area Agencies on Aging
AAP	American Academy of Pediatrics
AAPS	Addiction and Prevention Services
ABD	Aged, Blind and Disabled
ACH	Adult Care Home
ACIL	Attendant Care for Independent Living
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act
ADA	American Dental Association (depending upon context)
ADA-CAP	Americans with Disabilities Act Communications Accommodations Project
ADAAG	Americans with Disabilities Act Accessibility Guidelines
ADAP	AIDS Drug Assistance Program
ADC	Adult Day Care
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AIMS	Automated Information Management System
ALF	Assisted Living Facility
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMA	American Medical Association
ANE	Abuse, Neglect or Exploitation
ANSI	American National Standards Institute
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorders
AT	Assistive Technology
AVRS	Automated Voice Response System
B	
BAA	Business Associate Agreement
BCH	Boarding Care Home
BG	Block Grant
BMI	Body Mass Index
BSRB	Behavioral Sciences Regulatory Board
C	
CAD	Coronary Artery Disease
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CARC	Claim Adjustment Reason Codes
CARE	Client Assessment Referral and Evaluation
CBA	Community Based Alternatives
CBO	Community-Based Organization
CDC	Centers for Disease Control
CDDO	Community Developmental Disability Organization
CDT	Code on Dental Procedures and Nomenclature
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CHF	Congestive Health Failure

CHIP	Children's Health Insurance Program
CIL	Centers for Independent Living
CLIA	Medicaid Clinical Laboratory Improvement Amendments
CLIC	Centers for Independent Living
CME	Case Management Entity
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services (U.S. Department of Health & Human Services)
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CPI	Crisis Prevention Institute
CPT	Current Procedural Terminology
CRD	Chronic Renal Disease
CSHCN	Children with Special Health Care Needs
CSP	Community Service Providers
CSS	Community Supports and Services
CSW	Customer Service Worksheet
D	
DBHS	Disability and Behavioral Health Services
DD	Developmental Disability
DEERS	Defense Enrollment Eligibility Reporting System
DHCF	Division of Health Care Finance
DME	Durable Medical Equipment
DMH	Division of Mental Health
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
DTaP	Diphtheria and Tetanus Toxoids and Acellular Pertussis
DUI	Driving Under the Influence
DUR	Drug Utilization Review
E	
EBP	Evidence Based Practice
ECI	Early Childhood Intervention
EDI	Electronic Data Interface
EHR	Electronic Health Record
EPLS	Excluded Parties List System
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESD	Expedited Service Delivery
ESRD	End-Stage Renal Disease
EVV	Electronic Visit Verification
F	
FDA	Food and Drug Administration
FE	Frail Elderly
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMS	Financial Management System
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FY	Fiscal Year
G	

GCN	Generic Code Number
H	
HBIG	Hepatitis B Immune Globulin
HBsAg	Hepatitis B Surface Antigen
HCBS	Home and Community Based Services
HCERA	Health Care and Education Reconciliation Act of 2010
HCPCS	Health Care Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HepA	Hepatitis A
HepB	Hepatitis B
HH	Health Home
HHA	Home Health Agencies
HHS	The United States Department of Health and Human Services
HI	Head Injury
Hib	Haemophilus Influenzae Type B Conjugate
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HIPPS	Health Insurance Premium Payment System
HIS	Health Information System
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HMM	Health Maintenance Monitoring
HP	Home Plus
HPV	Human Papillomavirus Vaccine
HPV2	Bivalent HPV Vaccine
HPV4	Quadrivalent HPV Vaccine
HSA	Health Savings Account
I	
IA	Information and Assistance
IADL	Instrumental Activities of Daily Living
IBP/POC	Individualized Behavioral Program Plan of Care
ICF	Intermediate Care Facility
ICF/MH	Intermediate Care Facility for Mental Health
ICF/MR	Intermediate Care Facility for Mental Retardation
ICM	Independent Case Management
IcMMIS	Interchange Medicaid Management Information System
ICP	Individual Care Plan
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IFSP	Independent Family Services Plan
IIMC	Intermittent Intensive Medical Care
IIS	Intensive Individual Supports
ILC	Independent Living Center
IMD	Institution of Mental Disease
IP	Inpatient
IPV	Inactivated Poliovirus Vaccine
ISS	Interactive Survey System
IT Policy 1210	Kansas Information Technology Policy 1210: State of Kansas Web Accessibility Requirements
IUD	Intrauterine Device

IV	Intravenous
IVP	Inactivated Poliovirus Vaccine
K	
KAAAA	Kansas Association of Area Agencies on Aging (aka K4A)
KAR	Kansas Administrative Regulation
KBH	Kan Be Healthy
KBI	Kansas Bureau of Investigation
KCPC	Kansas Client Placement Criteria
KDHE	Kansas Department of Health and Environment
KDOA	Kansas Department on Aging
KHA	Kansas Hospital Association
KHIN	Kansas Health Information Network
KHS	Kansas Health Solutions
KHIE	Kansas Health Information Exchange
KID	Kansas Insurance Department
KMAP	Kansas Medical Assistance Program
KMED	Kansas Medical Eligibility Determination
KMS	Kansas Medical Society
KSA	Kansas Statutes Annotated
L	
LAC	Licensed Addiction Counselor
LACIE	Lewis and Clark Health Information Exchange
LAIV	Live, Attenuated Influenza Vaccine
LCAC	Licensed Clinical Addictions Counselor
LCE	Low Cost Estimate
LEA	Local Education Agencies
LEIE	List of Excluded Individuals/Entities
LMHP	Licensed Mental Health Professional
LTC	Long Term Care
M	
M&I	Maternal and Infant (Title V Program)
MAT	Medication Assisted Treatment
MATLOC	Medical Assistive Technology Level of Care Instrument
MCO	Managed Care Organization
MCS	Managed Care Services
MCV4	Meningococcal Conjugate Vaccine, Quadrivalent
MED	Medicare Exclusion Database
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person Grant
MH	Mental Health
MMIS	Medicaid Management Information System
MMR	Measles, Mumps and Rubella
MR	Mental Retardation or Mentally Retarded
MRT	MCO Report Template
MTM	Medication Therapy Management
N	
NAEPP	National Asthma Education and Prevention Program
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Code

NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NOMS	National Outcomes Measurement System
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration Systems
O	
OAH	Office of Administrative Hearings
OP	Outpatient
OT	Occupational Therapy
OTC	Over-the-Counter
P	
P4P	Pay for Performance
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PAHP	Pre-Paid Ambulatory Health Plan
PARIS	Public Assistance Reporting Information System
PASARR/PASRR	Preadmission Screening and Resident Reviews
PATH	Projects for Assistance in Transition from Homelessness
PBM	Pharmacy Benefit Managers
P-Card	Procurement Card
PCCM	Person Centered Case Management or Primary Care Case Management
PCP	Primary Care Provider or Primary Care Physician
PCV	Pneumococcal Conjugate Vaccine
PCV7	7-Valent PCV
PCV13	13-Valent PCV
PD	Physical Disability
PDL	Preferred Drug List
PERS	Personal Emergency Response System
PHI	Personal/Protected Health Information
PIHP	Pre-Paid Inpatient Plan
PIP	Performance Improvement Project
PIR	Payment Integrity Report
PMDD	Presumptive Medical Disability Determination
PMPM	Per Member Per Month
PNC	Procurement Negotiating Committee
POC	Plan of Care
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act
PPSV	Pneumococcal Polysaccharide Vaccine
PRTF	Psychiatric Residential Treatment Facility
PR	Psychical Rehabilitation
PS	Peer Support
PT	Physical Therapy
PW	Pregnant Women
Q	
QA	Quality Assurance
QAP	Quality Action Plan
QAPI	Quality Assessment & Performance Improvement
QI	Quality Initiative
QM	Quality Management

QMP	Quality Management Plan
QMPH	Qualified Mental Health Professional
OTC	Over-the-Counter
R	
RA	Remittance Advice
RADAC	Regional Alcohol and Drug Assessment Center
RARC	Reason & Remark Codes
RCIL	Resource Center for Independent Living
REC	Regional Extension Center
RFP	Request for Proposal
RHC	Rural Health Clinic
RHCF	Residential Health Care Facility
RPRF	Real and Personal Property Fee
RV	Rotavirus
S	
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SA-PIHP	Substance Abuse – Prepaid Inpatient Health Plan
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening Brief Intervention/Referral to treatment
SED	Serious Emotional Disturbance
SEHP	State Employee Health Plan
SFTP	Secure File Transfer Protocol
SGF	State General Fund
SHS	Special Health Services
SMC	Specialized Medical Care
SMHH	State Mental Health Hospital
SMHP	State Medicaid HIT Plan
SNF	Skilled Nursing Facility
SNIP	Strategic National Implementation Process
SOBRA	Sixth Omnibus Budget Reconciliation Act
SP	Medicaid State Plan
SPMI	Serious and Persistent Mental Illness
SRS	Kansas Department of Social and Rehabilitation Services
SSA	Social Security Administration
SSI	Supplemental Security Income
SSMA	Single State Medicaid Agency
ST	Speech Therapy
STD	Sexually Transmitted Diseases
SUD	Substance Use Disorder
T	
TA	Technology Assisted
TANF	Temporary Assistance for Needy Families (called TAF in Kansas)
TB	Tuberculosis
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TD	Tetanus and Diphtheria Toxoids
Tdap	Tetanus and Diphtheria Toxoids and Acellular Pertussis
TEDS	Treatment Episode Data Set
Title XIX	Of the Social Security Act – Federal Funds Source for Medicaid
Title XXI	Of the Social Security Act – Federal funds source for health insurance for low-

	income children (CHIP)
TIV	Trivalent Inactivated Influenza Vaccine
TPL	Third Party Liability
TTY/TTD	TeleTypewriter/Telecommunications Device
U	
UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URL	Universal/Uniform Resource Locator
V	
VAERS	Vaccine Adverse Event Reporting System
VFC	Vaccines for Children
VO-KS	ValueOptions - KS
VPAT	Voluntary Product Accessibility Template
W	
WIC	Special Supplemental Food Program for Women, Infants and Children

ATTACHMENT D
Member Grievances and Appeals
And Provider Complaints and Appeals

1.0 Member Grievances and Appeals

1.1 Member Grievance System
The CONTRACTOR must develop, implement, and maintain a member grievance system that complies with the requirements in applicable Federal and State laws and regulations, including 42 CFR §431.200, 42 CFR Part 438, Subpart F, "Grievance System," and the provisions of Kansas Statute 40-3228 relating to grievance procedures.
1.1.1
The grievance system must include a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process. Members may access the Office of Administrative Hearings (OAH) State Fair Hearing process at any time except when an expedited appeal is requested. Members must exhaust the CONTRACTOR's expedited appeal process prior to accessing the expedited State Fair Hearing process. The procedures must be the same for all members and must be reviewed and approved in writing by the State or its designee. Modifications and amendments to the member grievance system must be submitted for the State's approval at least 30 days prior to the implementation.
1.1.2
The CONTRACTOR shall establish a grievance system including written policies and procedures that meet the following requirements:
1.1.2.1
provides Members reasonable assistance in completing forms and other procedural steps, not limited to providing interpreter services and toll-free numbers with TeleTypewriter/Telecommunications Device (TTY/TDD) and interpreter capability;
1.1.2.2
acknowledges receipt of each grievance and appeal;
1.1.2.3
ensures that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Member's condition or disease if any of the following apply:
1.1.2.3.1
an appeal of a denial based on lack of medical necessity;
1.1.2.3.2
a grievance regarding denial of expedited resolution of an appeal;
1.1.2.3.3
any grievance or appeal involving clinical issues;
1.1.2.4
provides the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a subcontract:
1.1.2.4.1
the Member's right to a State Fair Hearing, how to obtain a hearing, and right to representation at a hearing;
1.1.2.4.2
the Member's right to file grievances and appeals and their requirements and timeframes for filing;
1.1.2.4.3
the availability of assistance in filing;
1.1.2.4.4
the toll-free numbers to file oral grievances and appeals;
1.1.2.4.5
the Member's right to request continuation of benefits (as defined in 42 C.F.R. § 438.420(b)(1)) during an appeal or State Fair Hearing; if the CONTRACTOR's Action in a State Fair Hearing is upheld, the Member may be liable for the cost of any continued benefits;

1.1.2.4.6
any State-determined provider appeal rights to challenge the failure of the organization to cover a service.
1.1.3
The CONTRACTOR must maintain records of all grievances and appeals received as noted below

1.2 Member Grievance Process
1.2.1
The CONTRACTOR must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving grievances by members or their authorized representatives through the grievance process. For purposes of this section**,** an "authorized representative" is any person or entity acting on behalf of the member and with the Member's written consent. A provider may be an authorized representative. The grievance process shall ensure the following:
1.2.1.1
The grievance procedure must be the same for all Members under this Contract.
1.2.1.2
The Member or Member's authorized representative may file a grievance either orally or in writing.
1.2.1.3
Members or their designee may file a grievance either orally or in writing;
1.2.1.4
The timeframe within which a Member must file a grievance is 180 days;
1.2.1.5
The CONTRACTOR may require others who are not Members or their designees to initiate the process with a written request;
1.2.1.6
The CONTRACTOR shall dispose of each grievance and provide notice, as expeditiously as the Member's health condition requires within 30 business days from the day the CONTRACTOR receives the grievance
1.2.3
The State may, in its reasonable discretion, grant a written extension if the CONTRACTOR demonstrates good cause but in no case may that extension result in a disposition of the grievance to exceed 60 days from the day the CONTRACTOR receives the grievance.
1.2.4
Unless the State has granted a written extension as described above, the CONTRACTOR is subject to remedies, including liquidated damages if Member grievances are not resolved by the timeframes indicated herein.
1.2.5
The CONTRACTOR must resolve 98% of grievances within 30 days from the date the grievance is received. The CONTRACTOR must resolve 100% of the grievances within 60 days from the date the grievance is received. The CONTRACTOR is subject to remedies, including liquidated damages, if the grievances are not resolved within the established timeframes. Please see ATTACHMENT G.
1.2.5.1
All decisions shall be in writing.
1.2.5.2
The CONTRACTOR must also inform Members how to file a grievance directly with the State, once the Member has exhausted the CONTRACTOR's grievance process.
1.2.6
The CONTRACTOR must designate an officer of the CONTRACTOR who has primary responsibility for ensuring that grievances are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR must have a routine process to detect patterns of grievances. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the grievances.
1.2.7
The CONTRACTOR's grievance procedures must be provided to Members in writing and through oral interpretive services. A written description of the CONTRACTOR's grievance procedures must be available in the prevalent non-English language identified by the State, at no more than a 6th grade reading level. The CONTRACTOR must include a written description of the grievance process in the

Member handbook. The CONTRACTOR must maintain and publish in the Member handbook, at least one (1) local and one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for making grievances. The CONTRACTOR's process must require that every grievance received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1.2.7.1
Date;

1.2.7.2
Identification of the individual filing the grievance;

1.2.7.3
Identification of the individual recording the grievance;

1.2.7.4
Nature of the grievance;

1.2.7.5
Disposition of the grievance (i.e., how the CONTRACTOR resolved the grievance);

1.2.7.6
Corrective action required; and

1.2.7.7
Date resolved.

1.2.8
The CONTRACTOR is prohibited from discriminating or taking punitive action against a Member or his/her representative for making a grievance.

1.2.9
If the Member makes a request for disenrollment, the CONTRACTOR must give the Member information on the disenrollment process and direct the Member to the State's fiscal agent. If the request for disenrollment includes a grievance by the Member, the grievance will be processed separately from the disenrollment request, through the grievance process.

1.2.10
The CONTRACTOR will cooperate with the State's fiscal agent and the State or its designee to resolve all Member grievances. Such cooperation may include, but is not limited to, providing information or assistance to internal CONTRACTOR grievance committees.

1.2.11
The CONTRACTOR must provide designated Member advocates to assist Members in understanding and using the CONTRACTOR's grievance system. The CONTRACTOR's Member advocates must assist Members in writing or filing a grievance and monitoring the grievance through the CONTRACTOR's grievance process until the issue is resolved.

1.3 Notices of Action for Medicaid Members

1.3.1
The CONTRACTOR must notify the Member, in accordance with Kansas Statutes and Federal regulations at 42 CFR 438.404 whenever the CONTRACTOR takes an action. The notice shall be in writing. It must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members must be informed that information is available in alternative formats and how to access those formats. The notice must, at a minimum, include any information required by Kansas Statute that relates to a managed care organization's (MCO) notice of action and any information required by 42 CFR §438.404 as well as 42 CFR 431 Subpart E, including but not limited to:

1.3.1.1
The dates, types and amount of service requested (if the action pertains to a service authorization request);

1.3.1.2
The action the CONTRACTOR has taken or intends to take;

1.3.1.3
The reasons for the action (If the action taken is based upon a determination that the requested service is not medically necessary, the CONTRACTOR must provide an explanation of the medical basis for the

decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in its notice to the Member.);

1.3.1.4
The Member's right to file an appeal through the CONTRACTOR's appeal process within 30 days of the notice of action;
1.3.1.5
The procedures by which the Member may appeal the CONTRACTOR's action;
1.3.1.6
The circumstances under which expedited resolution is available and how to request it
1.3.1.7
The circumstances under which a Member may continue to receive benefits pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
1.3.1.8
The date the action will be taken;
1.3.1.9
A reference to the CONTRACTOR policies and procedures supporting the CONTRACTOR's action;
1.3.1.10
An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an appeal, or request a fair hearing;
1.3.1.11
In the event of a State Fair Hearing, that:
1.3.1.11.1
The Member may represent him/herself or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
1.3.1.11.2
The specific regulations that support, or the change in Federal or State law that requires, the action; and
1.3.1.11.3
An explanation of the individual's right to an evidentiary hearing if one is available or a State Fair Hearing, or in cases of an action based on a change in law, the circumstances under which a hearing will be granted.
1.3.2
Timeframes for notice of action pertaining to Standard Service Authorization Denial:
1.3.2.1
CONTRACTOR shall give notice as expeditiously as the Member's health condition requires, which may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to fourteen additional calendar days, if the Member or the provider requests an extension; or the CONTRACTOR justifies a need for additional information and how the extension is in the Member's interest (upon the State's approval).
1.3.2.3
If the CONTRACTOR extends the timeframe, the CONTRACTOR shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the Member's health condition requires and not later that the date the extension expires.
1.3.3
Timeframes for notice of action pertaining to termination, suspension or reduction of services:
1.3.3.1
The CONTRACTOR shall give notice at least 10 calendar days before the date of the action when the action is a termination, suspension, or reduction of previously authorized T-XIX-covered services, except:
1.3.3.1.1
If probable fraud and abuse has been verified, the period of advanced notice is shortened to five (5) calendar days;
1.3.3.1.2
If one of the following events occurs, the period of advanced notice is shortened to the day of the Action:
1.3.3.1.2.1

The death of a recipient;
1.3.3.1.2.2
A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where the Member understands that this shall be the result of supplying that information);
1.3.3.1.2.3
The recipient's admission to an institution where he/she is ineligible for further services;
1.3.3.1.2.4
The recipient's address is unknown and mail directed to him has no forwarding address;
1.3.3.1.2.5
The recipient has been accepted for T-XIX services by another local jurisdiction;
1.3.3.1.2.6
The recipient's physician prescribes the change in the level of care; or
1.3.3.1.2.7
The previously authorized service is substituted with a higher level of service.
1.3.4
Timeframes for Notice of Action: Untimely Service Authorization Decision:
1.3.4.1
If service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations, such untimely service authorizations constitute a denial and are adverse actions.
1.3.5
Timeframes for Notice of Action pertaining to Denial of Payment:
1.3.5.1
The CONTRACTOR shall give notice to the provider and Member on the date of action when the action is a denial of payment. Notice is not required to the Member when the action is due to the provider's failure to adhere to contractual requirements and there is no action against the Member.
1.3.6
Timeframes for Notice of Action pertaining to Expedited Service Authorization Denial:
1.3.6.1
For cases in which a provider indicates, or the CONTRACTOR determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited authorization decision and provide notice of action as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for service. The CONTRACTOR may extend the three (3) business days time period by up to 14 calendar days if the Member requests an extension, or if the CONTRACTOR justifies a need for additional information and how the extension is in the Member's interest (upon the State's approval)

1.4 Medicaid Standard Member Appeal Process
1.4.1
The CONTRACTOR must develop, implement and maintain an appeal procedure that complies with State and Federal laws and regulations, including 42 CFR§ 431.200 and 42 CFR Part 438, Subpart F, "Grievance System." The appeal procedure must be the same for all Members. The Member or provider may file an appeal either orally or in writing; however, an oral request to appeal shall be followed by a written, signed, appeal. The CONTRACTOR shall ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing upon receipt of the written, signed appeal, unless the Member or the provider requests expedited resolution. When a Member or his/her authorized representative expresses orally or in writing requests review of an action, the CONTRACTOR must regard this as a request to appeal an action.
1.4.2
A Member must file a request for an appeal with the CONTRACTOR within 30 days from receipt of the notice of the action.
1.4.3
The Contractor shall provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CONTRACTOR shall allow the Member and the Member's representative the opportunity, before and during the appeal process, to examine the Member's case file,

including clinical records, and any other documents and records. The CONTRACTOR must inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.
1.4.4
The CONTRACTOR must have policies and procedures in place outlining the officer's role in an appeal of an action. The officer must have a significant role in monitoring, investigating and hearing appeals.
The CONTRACTOR must have a routine process to detect patterns of appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the appeals.
1.4.5
The CONTRACTOR's appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the appeal procedures must be available in the prevalent non-English language identified by the State, at no more than a 6th grade reading level.
1.4.6
The CONTRACTOR must include a written description of the appeals process in the Member handbook. The CONTRACTOR must maintain and publish in the Member handbook at least one (1) local and one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an appeal of an action.
1.4.7
All appeals must be recorded in a written record and logged with the following details:
1.4.7.1
Date notice is sent;
1.4.7.2
Effective date of the action;
1.4.7.3
Date the Member or his or her representative requested the appeal;
1.4.7.4
Date the appeal was followed up in writing;
1.4.7.5
Identification of the individual filing;
1.4.7.6
Nature of the appeal; and
1.4.7.7
Disposition of the appeal, and notice of disposition to Member.
1.4.8
The CONTRACTOR must send a letter to the Member within five (5) business days acknowledging receipt of the appeal request.
1.4.9
In accordance with 42 CFR§ 438.420(b), the CONTRACTOR must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the appeal, if all of the following criteria are met:
1.4.9.1
The Member or his or her representative files the appeal timely, meaning on or before the later of the following: within 10 days of the MCO mailing the notice of action or the intended effective date of the MCO proposed action;
1.4.9.2
The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
1.4.9.3
The services were ordered by an authorized provider;
1.4.9.4
The original period covered by the authorization has not expired; and
1.4.9.5
The Member requests an extension of the benefits.
1.4.10

If, at the Member's request, the CONTRACTOR continues or reinstates the Member's benefits while the appeal is pending either at the CONTRACTOR or the State Fair Hearing, the benefits must be continued until one (1) of the following occurs:

1.4.10.1
The Member withdraws the appeal;

1.4.10.2
The Member does not request a fair hearing within 10 days from when the CONTRACTOR mails an adverse CONTRACTOR decision;

1.4.10.3
A State Fair Hearing officer issues a hearing decision adverse to the Member or

1.4.10.4
The authorization expires or authorization service limits are met.

1.4.11
If the authorization period has expired or the authorized units of service are exhausted, Members or their designee may request an extension of services. Such extensions are considered a new request for services, however; and the CONTRACTOR is not obligated to continue services if such new request is denied.

1.4.12
In accordance with 42 CFR§ 438.420(d), if the final resolution of the appeal is adverse to the Member and upholds the CONTRACTOR's action, then to the extent that the services were furnished to the enrollee while the appeal was pending to comply with the Contract continuation of benefits requirements, the CONTRACTOR may recover such costs from the Member.

1.4.13
The CONTRACTOR shall consider the Member's representative, or an estate representative of a deceased Member as parties to the appeal. A Member may seek a State Fair Hearing if the Member is not satisfied with the CONTRACTOR's decision in response to an appeal.

1.4.14
The CONTRACTOR shall resolve 95%of appeals and provide notice, as expeditiously as the Member's health condition requires within 14 calendar days from the date the CONTRACTOR receives the written appeal, and 100% shall be resolved within 30 calendar days;

1.4.14.1
the CONTRACTOR may extend the initial 14 calendar day timeframe by up to 14 calendar days if the Member requests the extension;

1.4.14.2
the CONTRACTOR may extend the initial 14 calendar day timeframe by up to 14 calendar days, with approval by the State, when the CONTRACTOR shows that there is need for additional information and how the delay is in the Member's interest. The CONTRACTOR shall notify the Member of the reason for the extension, and

1.4.15
The CONTRACTOR is subject to remedies, including liquidated damages, if at least 98% of Member appeals are not resolved within 30 days of receipt of the Appeal by the CONTRACTOR. Please see ATTACHMENT G. The CONTRACTOR must designate an officer who has primary responsibility for ensuring that appeals are resolved in compliance with written policy and within the 30-day time limit.

1.4.16
The CONTRACTOR shall provide written notice of appeal resolution. The written appeal resolution notice shall include:

1.4.16.1
the results and date of the appeal resolution;

1.4.16.2
for decisions not wholly in the Member's favor:

1.4.16.2.1
the right to request a State Fair Hearing within 30 days;

1.4.16.2.2
how to request a State Fair Hearing;

1.4.16.2.3

the right to continue to receive benefits (pursuant to 42 CFR 438.420) pending a hearing;
1.4.16.2.4
how to request the continuation of benefits in a timely manner; and
1.4.16.2.5
notice that if the CONTRACTOR's action is upheld in a hearing, the Member may be liable for the cost of any continued benefits;
1.4.16.3
that in the State Fair Hearing the Member may represent him/herself or use legal counsel, a relative, a friend, or a spokesperson;
1.4.16.4
the specific regulations that support, or the change in Federal or State law that requires, the action, and
1.4.16.5
an explanation of the individual's right to request an evidentiary hearing if one is available or a State Fair Hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
1.4.16.6
Any other information required by Kansas Statute that relates to a managed care organization's notice of disposition of an appeal.
1.4.17
If the CONTRACTOR or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CONTRACTOR must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.
1.4.18
If the CONTRACTOR or State Fair Hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending, the CONTRACTOR is responsible for the payment of services.
1.4.19
The CONTRACTOR is prohibited from discriminating or taking punitive action against a Member or his/her representative for making an appeal.

1.5 Expedited Medicaid Member Appeals
1.5.1
In accordance with 42 CFR §438.410, the CONTRACTOR must establish and maintain an expedited review process for appeals, when the CONTRACTOR determines (for a request from a Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The CONTRACTOR must follow all appeal requirements for standard Member appeals as set forth in this ATTACHMENT except where differences are specifically noted. The CONTRACTOR must accept oral or written requests for expedited appeals.
1.5.2
No additional Member follow-up is required. The CONTRACTOR shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.
1.5.3
Members must exhaust the CONTRACTOR's expedited appeal process before making a request for an expedited fair hearing.
1.5.4
After the CONTRACTOR receives the request for an expedited appeal, it must dispose each expedited appeal and notify the Member of the outcome of the expedited appeal, as expeditiously as the Member's health condition requires, within three (3) business days, except that the CONTRACTOR must complete investigation and resolution of an appeal relating to an ongoing emergency or denial of continued hospitalization not later than one (1) business day after receiving the Member's request for expedited appeal is received.
1.5.5
Except for an appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the expedited appeal may be extended up to 14

calendar days if the Member requests an extension or the CONTRACTOR shows (to the satisfaction of DHCF, upon DHCF's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the CONTRACTOR must give the Member written notice of the reason for delay if the Member had not requested the delay. In addition to written notice, the CONTRACTOR must also make reasonable efforts to provide oral notice. The CONTRACTOR is prohibited from discriminating or taking punitive action against a Member or his/her representative for requesting an expedited appeal. The CONTRACTOR must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

1.5.6

If the CONTRACTOR denies a request for expedited resolution of an appeal, it shall:

1.5.6.1

transfer the appeal to the standard timeframe for an appeal, and

1.5.6.2

make reasonable efforts to give the Member prompt oral notice of the denial and give a written notice within two (2) calendar days.

1.5.7

This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.

1.5.8

If the decision is adverse to the Member, the CONTRACTOR must follow the procedures relating to the appeal resolution notice described above. The CONTRACTOR is responsible for notifying the Member of his/her right to access an expedited fair hearing from OAH. The CONTRACTOR will be responsible for providing documentation to the State and the Member, indicating how the decision was made, prior to OAH's expedited fair hearing.

1.6 Access to Fair Hearing for Medicaid Members

1.6.1

The CONTRACTOR must inform Members that they have the right to access the fair hearing process at any time during the appeal system provided by the CONTRACTOR. In the case of an expedited fair hearing process, the CONTRACTOR must inform the Member that he/she must first exhaust the CONTRACTOR's internal expedited appeal process prior to filing an expedited fair hearing. The CONTRACTOR must notify Members that they may be represented by an authorized representative in the fair hearing process.

1.6.2

If a Member requests a fair hearing, the CONTRACTOR will complete the OAH request for fair hearing, and submit the form electronically to the appropriate fair hearings office, within five (5) calendar days of the Member's request for a fair hearing.

1.6.3

Within five (5) calendar days of notification that the fair hearing is set, the CONTRACTOR will prepare an evidence packet for submission to the State fair hearings staff and send a copy of the packet to the Member. The evidence packet must comply with the State's fair hearings requirements.

1.6.4

The State OAH is responsible for the State Fair Hearing. The State must reach its decisions within the specified timeframes:

1.6.4.1

Standard resolution: within 90 days of the date the enrollee filed the appeal with the CONTRACTOR if the enrollee filed initially with the CONTRACTOR (excluding the days the enrollee took to subsequently file for a State Fair Hearing) or the date the enrollee filed for direct access to a State Fair Hearing.

1.6.4.2

Expedited resolution (if the appeal was heard first through the CONTRACTOR appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that:

1.6.4.2.1

Meets the criteria for an expedited appeal process but was not resolved using the CONTRACTOR's expedited appeal timeframes, or

1.6.4.2.2

Was resolved wholly or partially adversely to the enrollee using the CONTRACTOR's expedited appeal

timeframes.
1.6.5
The State is a party to the State Fair Hearing and may be represented by the CONTRACTOR. The Member or the Member's estate is also a party and may be represented.
1.6.6
The CONTRACTOR must ensure that any Member dissatisfied with determination denying a beneficiary's request to transfer plans/disenroll is given access to a State Fair Hearing.

1.7 Member Advocates
1.7.1
The CONTRACTOR must provide Member advocates to assist Members. Member advocates must be physically located within Kansas unless an exception is approved by the State. Member advocates must inform Members of the following:
1.7.1.1
Their rights and responsibilities,
1.7.1.2
The grievance process,
1.7.1.3
The appeal process,
1.7.1.4
Covered services available to them, including preventive services, and
1.7.1.5
Non-capitated services available to them.
1.7.2
Member advocates must assist Members in writing grievances and appeals and are responsible for monitoring the grievances and appeals through the CONTRACTOR's Grievance System.
1.7.3
Member advocates are responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. Member advocates are also responsible for helping or referring Members to community resources available to meet Member needs that are not available from the CONTRACTOR as Medicaid covered.
1.7.4
Member enrollment information must include how Members can contact Member advocates by phone, e-mail, or letter.

2. 0 Provider Complaints and Appeals

2.1 Provider Complaints
2.1.1
Medicaid CONTRACTORs must develop, implement, and maintain a system for tracking and resolving all Medicaid provider complaints. Within this process, the CONTRACTOR must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each provider complaint. The CONTRACTOR must resolve provider complaints within 30 days from the date the complaint is received. The CONTRACTOR is subject to remedies, including liquidated damages, if at least 98% of provider complaints are not resolved within 30 days of receipt of the complaint by the CONTRACTOR. Please see ATTACHMENT G.
2.1.2
CONTRACTORs must also resolve provider complaints received by the State no later than the due date noted upon the State's notification. The State will generally provide CONTRACTORs 10 business days to resolve such complaints. If a CONTRACTOR cannot resolve a complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. The State may, in its reasonable discretion, grant a written extension if the CONTRACTOR demonstrates good cause.
2.1.3
Unless the State has granted a written extension as described above, the CONTRACTOR is subject to remedies, including liquidated damages if provider complaints are not resolved by the timeframes indicated herein.

2.2 Provider Appeals

2.2.1

CONTRACTORs must develop, implement, and maintain a system for tracking and resolving all Medicaid provider appeals related to claims payment or other contracting issues including removal from the CONTRACTOR's provider network. Within this process, the CONTRACTOR must respond fully and completely to each Medicaid provider's appeal and establish a tracking mechanism to document the status and final disposition of each provider's appeal.

2.2.1

For claims payment issues, Medicaid CONTRACTORs must contract with physicians who are not network providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal. The determination of the physician resolving the dispute must be binding on the CONTRACTOR and the provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing provider. The State reserves the right to amend this process to include an independent review process established by the State for final determination on these disputes.

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.

ATTACHMENT G
Amended December 9, 2011
Liquidated Damages

Purpose: The purpose of liquidated damages is to ensure adherence to the performance requirements in the Contract. No punitive intention is inherent. It is agreed by the State and the CONTRACTOR that, in the event of a failure to meet the performance requirements listed below damage shall be sustained by the State, and that it is and shall be impractical and extremely difficult to ascertain and determine the actual damages which the State shall sustain in the event of, and by reason of, such failure; and it is therefore agreed that the CONTRACTOR shall pay the State for such failures at the sole discretion of the State according to the following sections and attachments found in the table below.

Damage assessments are linked to performance of system implementation or operational responsibilities. Where an assessment is defined as an "up to $,$$$" amount, the dollar value shall be set at the discretion of the State.

With the exception of the requirement to begin operations on January 1, 2013, written notification of each failure to meet a performance requirement shall be given to the CONTRACTOR prior to assessing liquidated damages. The CONTRACTOR shall have five (5) business days from the date of receipt of written notification of a failure to cure the failure or submit a corrective action plan (CAP). The plan must be approved by the State. If the failure is not resolved within this warning/cure period, liquidated damages may be imposed retroactively to the date of failure to perform. The imposition of liquidated damages is not in lieu of any other remedy available to the State.

If the State elects to not exercise a damage clause in a particular instance, this decision shall not be construed as a waiver of the State's rights to pursue future assessment of the performance requirement and associated damages.

Deductions of Damages from Payments: The State may deduct amounts due as actual or liquidated damages from any monies payable to the contractor pursuant to its Contract. The State shall notify the CONTRACTOR of any claim for damages prior to the date upon which such monies are deducted from monies payable to the CONTRACTOR.

Performance Guarantees

	Requirement	Liquidated Damages
1.	**Start up:** CONTRACTOR must be appropriately staffed and trained to begin operations and provide services at 7:00 am CST January 1, 2013	
2.	**Start up:** CONTRACTOR shall provide to the State all deliverables within the time frames indicated following Contract award, including all deliverables specified in RFP Section 3.4 and Attachment K	$1,000 per calendar day for each day a deliverable is late, inaccurate or incomplete.
3.	**General Requirement:** CONTRACTOR fails to timely perform an MCO Administrative Services that is not otherwise associated with a performance standard in this matrix and, in the determination of the State, such failure either: (1) results in actual harm to the member or places a member at risk of imminent harm, or (2) materially affects State's ability to administer the Programs(s).	$1,000 per calendar day for each incident of non-compliance.
4.	**General Requirement:** CONTRACTOR fails to timely provide an MCO covered service that is not otherwise	$1,000 per calendar day for each incident of non-compliance.

	associated with a performance standard in this table and, in the determination of the State, such failure results in actual harm to a member or places a member at risk of imminent harm. RFP section 2.2.1, 2.2.15, Contract Attachment F	
5.	**Provider Network:** CONTRACTOR must submit to the State, documentation that demonstrates the provider network offers an appropriate range of specialty services that is adequate for the anticipated number of members. RFP section 2.2.8, 2.2.10	$1,000 per calendar day for each day the documentation is late, inaccurate or incomplete.
6.	**Provider Information Accuracy:** RFP Section 2.2.8 generally	$5,000.00 per quarter if data for more than 10% but fewer than 30% of providers is incorrect for each data element. $25,000.00 per quarter if data for more than 30% of providers is incorrect for each data element. The $25,000.00 liquidated damage may be lowered to $5,000.00 in the event that the Contractor provides a corrective action plan that is accepted by the State in writing.
7.	**Approval of materials:** all materials sent to the plan participants shall be approved by the State prior to printing and distribution. RFP Sections 2.2.17; 2.3.3.2	Failure to submit material for approval will be assessed a $1000.00 per incident liquidated damage.
8.	**Reports and Data Delivery: Timeliness:** Reporting requirements and standards are found throughout the Contract and attachments. This performance requirement applies to all reports and data to be delivered to the State or its designee. Reports and data must be produced in the format and media approved by the State. The State and the CONTRACTOR must agree in writing as part of the requirements on reports and data to be delivered to the State and its appropriate designee or distributed as required by the State according to a defined schedule.	1st time 'late' /1-10 days: $5,000 1st time 'late' /11-20 days: $10,000 1st time 'late' /over 21 days: $15,000 2nd time 'late'/1-10 days: $10,000 2nd time 'late'/11-20 days: $20,000 2nd time 'late'/over 21 days: $30,000 3rd time 'late'/1-10 days: $20,000 3rd time 'late'/11-20 days: $40,000 3rd time 'late'/over 21 days: $60,000
9.	**Reports and Data Delivery: Accuracy:** Reporting requirements and standards are found throughout the Contract and attachments. The CONTRACTOR is responsible for the accuracy of all reports, including calculations and completeness of data used as input	$500.00 per business day shall be assessed for each business day for each report that has been identified as inaccurate from the date of notification until the date the State approved, corrected report is delivered and accepted by the State.
10.	**Encounter Data:** CONTRACTOR shall prepare and submit encounter data as prescribed in Attachment K to the State through the State's designated fiscal agent. RFP Section 2.2.27; 2.2.33 and Attachment K	$5,000.00 per quarter if more than 10% but fewer than 30% of encounter data is missing or incorrect. $25,000.00 per quarter if more than 30% of encounter data is missing or incorrect. The $25,000.00 liquidated damage may be lowered to $5,000.00 in the event that the Contractor provides a corrective

		action plan that is accepted by the State in writing.
11.	**Claims Processing: Timeliness:** CONTRACTOR must pay all claims timely. The CONTRACTOR is responsible for submitting information about services rendered and reimbursed in the HIPAA required formats specified in the 837 Institutional Claim and Encounter Transactions, the 837 Professional Services Claim and Encounter Transactions companion guides and NCPDP standards. RFP Section 2.2.38	$10,000.00 for each month determined to be non-compliant
12.	**Personnel:** CONTRACTOR must provide staff to perform all tasks specified in this Contract. CONTRACTOR is responsible for maintaining a level of staffing necessary to perform and carry out all of the functions, requirements, roles and duties. RFP Section 2.2.41	$1,000.00 per calendar day per position for each day after the thirty (30) allowed calendar days that a key position may be vacant.
13.	**General Access Standards:** CONTRACTOR shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of covered services, including all emergency services, on a 24 hour a day, 7 day a week basis. Section 2.2.15	$25,000.00 if **ANY** of the listed standards are not met, either individually or in combination, on a monthly basis.
14.	**Member Grievances:** CONTRACTOR must resolve 98% of grievances within 30 days from the date the grievance is received. CONTRACTOR must resolve 100% of grievances within 60 days from the date of the grievance is received. Attachment D	$10,000.00 for each quarter determined to be non-compliant
15.	**Member Appeal Process**: CONTRACTOR must resolve 98% of member appeals within 30 days of receipt of the appeal by the CONTRACTOR. Attachment D	$10,000.00 for each quarter determined to be non-compliant
16.	**Provider Complaints:** CONTRACTOR must resolve 98% provider complaints within 30 days from the date the complaint is received. Attachment D	$10,000.00 for each quarter determined to be non-compliant
17.	**Customer Service Center:** 100% of incoming and outgoing calls must be documented. 99% of calls will be answered by an individual or an electronic device without receiving a busy signal. 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one (1) minute. 90% of calls answered will be resolved by the CONTRACTOR during the initial contact. 100% of received phone calls are recorded and recordings maintained. 98% of the time, facsimile (FAX) lines shall meet customer demand. RFP Section 2.2.42.	$10,000 for each full percentage point below requirement.
18.	**Miscellaneous Damages:** The objective of this section is to provide the State with an administrative procedure to address general contract compliance issues not defined elsewhere in this agreement. The State may identify a condition resulting from the CONTRACTORs' non-	If the non-compliance is not corrected by the specified date, the State reserves the right to assess liquidated damages in an amount not to exceed five hundred dollars ($500) per working day per

	compliance with the Contract through outline monitoring activities. If this occurs, the State will notify the CONTRACTOR in writing of the contractual non-compliance. The CONTRACOTR must provide a written response to the notification within five (5) business days of receipt of the notice. The State will recommend, when appropriate, a reasonable period of time within which the CONTRACTOR shall remedy the non-compliance. This liquidated damage may be independent or combined with any of the other liquidated damages listed above.	occurrence after the due date until the non-compliance is corrected.

ATTACHMENT H
Amended 12/09/2011
Reports

This is a preliminary list of the reporting requirements described throughout the CONTRACT and other ATTACHMENTS. The CONTRACTOR shall include a narrative summary to reports/submissions and may include graphs that explain and highlight key trends. The CONTRACTOR shall comply with all the reporting requirements established by the State. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the liquidated damages described in ATTACHMENT G.

For all the reports listed below, unless otherwise specified, if the CONTRACTOR meets the target for a given report, the CONTRACTOR shall only complete a short narrative description on the report cover sheet. For any report that indicates that the CONTRACTOR is not meeting the target, the CONTRACTOR shall submit a detailed narrative that includes the results, an explanation as to why the CONTRACTOR did not meet the target, and the steps the CONTRACTOR is taking to improve performance going forward.

All reports, unless otherwise specified by the State, shall be stratified. Stratification includes:

- Population groups;
- Service type; or
- Other stratification as requested by the State.

The CONTRACTOR shall submit all reports electronically in the form and format required by the State and shall participate with the State in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate. Targets shall be changed to reflect improvement in standards over time. The CONTRACTOR shall participate with the State prior to January 1, 2013 in the development of the report formats to be produced by the CONTRACTOR.

The State may, at its discretion, change the content, format or frequency of reports during the term of the contract. The State shall notify the CONTRACTOR of any updates to the report content, formats or frequency and the CONTRACTOR shall comply with all changes specified by the State.

The CONTRACTOR shall transmit to and receive from the State all transactions and code sets in the appropriate standard formats as specified under Federal and State regulations and as directed by the State, so long as the State direction does not conflict with the law.

The following table is a summary of the periodic reporting requirements for the CONTRACTOR and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the CONTRACTOR's responsibilities in any manner. The deliverables listed below are due by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

Name of report	Reporting frequency	Report description	Report Due to State
Encounter Data	Weekly	The CONTRACTOR shall prepare and submit encounter data as prescribed in Attachment K to the State through the State's designated Fiscal Agent. Each CONTRACTOR is required to have a valid MMIS Provider Identification Number including a unique identifier. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the CONTRACTOR has received and processed from provider encounter or claim records of all contracted services rendered to the Member in the current or any preceding months. Submissions must be received by the Fiscal Agent in accordance with Attachment K. CONTRACTOR(S) will submit attestation concurrently with each encounter data submission which states all of the data submitted are, to the best of the CONTRACTOR'S information, knowledge and belief, accurate and complete	As specified by the State
EPSDT Report	Monthly	EPSDT services and reporting shall comply with 42 CFR 411 Subpart B	As specified by the State
Fraud and Abuse Report	Quarterly	The number of complaints of fraud and abuse made to KDHE/DHCF that warrant preliminary investigation, and, for each complaint which warrants investigation, the following information: name-ID number; source of complaint; type of provider; nature of complaint; approximate dollars involved; legal and administrative disposition of the case	As specified by the State
Grievance and Appeal Reports	Quarterly	Report shall summarize formal grievance, appeals, administrative law hearing requests and informal inquiries and resolutions. The report shall summarize formal grievances and appeals and informal inquiries and resolutions (customer service report).	
Health Risk Assessments Report	Quarterly	The number of health risk assessments completed, as well as a summary and analysis of the information collected as it pertains to the prevalence of chronic conditions, need for preventive care, referrals to prenatal care (including the month a pregnant member was identified and screened), and relevant demographic and regional information.	As specified by the State
Hysterectomies and Sterilizations Report		Hysterectomies and sterilizations shall comply with 42 CFR 441 Subpart F. This includes completion of the consent forms.	As specified by the State

Name of report	Reporting frequency	Report description	Report Due to State
Pharmacy Report	Quarterly/On Request	Report to include a list of the providers and information on the interventions the CONTRACTOR has taken with the providers how appear to be operating outside industry or peer norms, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patters and/or failing to follow required prior authorization processes and procedures. The steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.	As specified by the State
QAPI Report	Annually	As outlined in Attachment J.	As specified by the State
Member Services and Provider Services Phone Line Report	Monthly	Monitoring of member services, provider services, nurse/triage nurse advice and utilization management lines. Data in the report shall be recorded weekly and shall include the detailed rate calculations.	15 days after month end
Utilization Management Report	Annually	Analysis of data and identification of opportunities of improvement and follow up of the effectiveness of the intervention. Utilization data is to be reported based on claim data. Include specific data in Section 2.2.40	As specified by the State
Financial Statements	Quarterly & Annually	As outlined in Section 2.2.28.5.9	As specified by the State
Claims processing/payment Reports	Quarterly	Report to the State enumerating the total number of claims processed during the preceding quarter; percentages of claims paid within 30 days, 60 days and 90 days; and average number of days to pay claims.	As specified by the State
Continuity of Business Operations Plan	Annually	Disaster Recovery Plan	As specified by the State
Access to Care Report		Report pursuant to Section 2.2.15 General Access Standards.	As specified by the State
Licenses Verification	Annually	Provide to the State and EQRO information for verification of Licenses for CONTRACTORS & subcontractors.	As specified by the State
Member Assignment Reports	Monthly	Member assignment to PCP at least one(1) time per month or as assigned by the State and the fiscal agent.	As specified by the State.
Provider network reports	Quarterly	Updated provider network report will include information on all providers of health services, including physical, behavioral health and long-term care providers as outlined in section 2.2.8	As specified by the State.
Institutional Discharges Report	Monthly	Member institutional discharges by category: Inpatient Psychiatric, State Hospital, State Hospital Alternative, PRTFs, nursing facilities, inpatient hospitals	15 days after month end

Name of report	Reporting frequency	Report description	Report Due to State
Customer service report Call Volume Call Timeliness Call Abandonment	Monthly	Measure ACD for all incoming calls The Customer Service call stats report will provide information on total calls received, calls abandoned within 30 seconds, % abandoned, average talk time, average speed of answer, and % answered within 30 seconds by month summarized quarterly and annually. Should also contain the original contact resulting in a formal grievance or appeal with a resolution of 'sent to grievances and appeals process."	15 days after month end
Service authorizations, service denials, and pending service authorizations	Monthly	Number of authorization requests, hours approved and denied, reasons for denial, approved units, paid units, % paid to approved units. This report shall be stratified by program and population as specified by the State.	15 days after month end
Utilization of Services by Service Type and Average Service Utilization	Monthly	Unduplicated count of members receiving any service, total number of all service units paid, grand total amount paid, average number of hours per member, and average amount paid per member. Separate reports for programs as requested by the State.	15 days after month end
Claims Reports	Monthly	Number of open, pended, processed and denied claims in the following categories: 30 days and under, 31-60 days, 61-90 days, over 90 days	15 days after month end
Claims Paid by Provider Type Report	Monthly	Total dollars paid and % of total paid to each of the following provider types: Community Mental Health Centers, Child Welfare Contractors, and Private Providers	15 days after month end
Claims Denial Detail Report	Monthly	The top claims denial reasons. Report will show the highest percentages for each denial reason. Report accompanies Claims Payment Timeliness and Accuracy reports and is contingent on whether claims are high (15% & above).	As specified by the State
Standard Services Preauthorization Decisions Report	Monthly	Total number of standard pre-authorizations: 0-5 days, 6-14 days, > 14 days, and total number of expedited pre-authorizations: 1 day, 2-3 days	15 days after month end
Provider Network Report	Monthly	Net additions/subtractions to the existing provider network based on the following categories: Community Mental Health Centers, Child Welfare Contractors, and Private Providers	15 days after month end
Incidents, Accidents, and Deaths Summary and Trending Report	Monthly	Total incidents, accidents, and deaths received by category, % of total by category accompanied by pie chart representation of data	15 days after month end

Name of report	Reporting frequency	Report description	Report Due to State
Third-party Liability (TPL) Review/Exception Summary Report	Monthly	Total TPL claim lines processed, paid, and denied, include a summary of cost avoidance	15 days after month end
Third Party Liability Report	Quarterly	By category: Medicare, Health Insurance, Spenddown – Claimed and approved amounts, Primary insurer allowable amount, primary insurer paid amount, paid amount, COB savings	30 days after quarter end
Income and Expense Statement (Unaudited)	Quarterly	Revenue, Administrative Services Revenue, Expenses, Net Income (Loss)	30 days after quarter end
Statement of Financial Position	Quarterly	Assets -- Total Cash, Total Reimbursement Funds, Total Investments, Total Other Assets, Total Current Assets, Net Fixed Assets, Liabilities and Equity -- Total Current Liabilities, Total Liabilities, Total Equity	30 days after quarter end
Incurred but Not Reported (INBR) Claims Report	Quarterly	Liability Type (Amount), Administrative Costs Incurred but Not Reported (Amount)	30 days after quarter end
Clean Claims Payment Timeliness and Accuracy Report	Quarterly	# of Lines and % of Total for claims paid and denied by the following categories: 0-30 days, 31-60 days, 61-90 days, >90 days	30 days after quarter end
Group 2 Paid Claims Report	Monthly	A monthly report of Group 2 paid claims. SRS is obligated to reimburse the CONTRACTOR for the payments made for Group 2 beneficiaries. This report is needed to ensure correct federal reporting for these claims. Data certification must be submitted concurrently.	As specified by the State
Provider Credentialing Report	Quarterly	Individual Providers: complete applications processed in 30 days and more than 30 days; CMHCs: complete applications processed in 30, 90, and more than 90 days	30 days after quarter end
Credentialing Review	Annually	Review of credentialing files by audit done at on-site visits. SRS Licensing reports included in CONTRACTOR's credentialing files	As specified by the State
Network Adequacy Assurance	Quarterly	Total # members, Total members in range, total members outside range, % in range, by geographic designation: Urban/semi-urban, densely settled, and rural/frontier.	30 days after quarter end
Call Center Access and Responsiveness Report	Quarterly	By member and by provider: average speed of answer, call abandonment percentage, # busy signals, hold time in seconds	30 days after quarter end

Name of report	Reporting frequency	Report description	Report Due to State
Overview of Corporate Compliance Department Activity	Quarterly	Cumulative data regarding routine Medicaid Claim Verification Audits, overpayment reasons pre and post appeal. Separate reports for programs as specified by the State.	30 days after quarter end
Member Outreach and Educational Offerings Report	Quarterly and Annually	Description of activity and number of attendees at outreach activities and educational offerings for members. Quarterly cumulative reports by fiscal year showing outreach activities such as meetings, presentations, coalition involvement, recovery focused events and tip sheets. Outreach will also be shown for priority populations. A new plan for the coming fiscal year will be included with the combined quarterly/annual report due in January. Also: Review of reports at annual onsite visit	30 days after quarter end and 30 days after fiscal year end
New Member Mailings Report	Quarterly	Total New Member Names Received, information distributed 0-15 days, information distributed 16+ days, total number of member distributions	30 days after quarter end
Critical Incident Report	Quarterly	Type of incident, and number of incidents reported by providers	30 days after quarter end
Grievance Summary and Trends Report	Quarterly	Type of grievance and number of grievances per catchment area.	30 days after quarter end
Out-of-state Placement and Treatment Summary	Quarterly	State, name of facility, type of facility (inpatient psych, PRTF, or inpatient hospital), age ranges 0-4, 5-12, 13-17, and 18+	30 days after quarter end
CAHPS/HEDIS Report	Annually	Submit an annual report of audited CAHPS results and audited HEDIS results.	30 days after fiscal year end
Continuity of Business Operations Plan	Annually	Disaster Recovery Plan	30 days after fiscal year end
Provider Manual Updates	Annually	Summary of Provider Manual Updates/new Provider Manual	30 days after fiscal year end
Member Handbook Updates	Annually	Summary of Member Handbook Updates/new Member Handbook	30 days after fiscal year end
Provider Satisfaction Survey	Annually	Copy of latest Provider Satisfaction Survey	30 days after fiscal year end
Provider Network Development Plan and Education	Annually	Summary of efforts to develop and educate the existing provider network as well as analysis of trends and plans for further provider network development and education for the upcoming fiscal year.	30 days after fiscal year end

Name of report	Reporting frequency	Report description	Report Due to State
Provider Report Card /NOMS	Annually	Provider Performance Indicators designed to monitor data that ensures quality services with positive clinical outcomes. NOMS Outcome Reporting including: SAMHSA National Outcome Measures NOMS (Abstinence, Employment/Education, Crime and criminal Justice Involvement, Stability in Housing, Social Connectedness) Access/Capacity, Retention, Perception of care, Cost-Effectiveness and Use of Evidenced-based Practices etc.	30 days after fiscal year end
Geographic Mapping Reports	Annually	Geographic mapping reports detailing single and multiple provider locations by the following categories: Urban/suburban, Densely settled, Rural/Frontier.	30 days after fiscal year end
Quality Assessment and Performance Improvement Work Plan	Annually	Detailed summary of annual quality assessment/performance improvement efforts and results of those efforts.	30 days after fiscal year end
Member Satisfaction Survey	Annually	Copy of latest Member Satisfaction Survey	30 days after fiscal year end
Parties of Interest Transactions Statement	Annually	Summary detailing transactions with parties of interest relating to the furnishing of services in the administration of the contract.	30 days after fiscal year end
Claims Data by FQHC and RHC In and Out of Network Providers	Annually	The FQHC and RHC Claims report provides a combined annual payment history displayed by month for all network and non-network FQHCs and RHCs providing services to Medicaid clients. The details of the report include the provider number, provider name, service rendered, check number, check paid data, and total amount paid.	Monthly when activity occurs
Final Independently Audited Financial Statements	Annually	Report of the Auditors of the Contractor This is an annual independent audit of the CONTRACTOR's statutory statements of admitted assets, liabilities, capital and surplus of the CONTRACTOR and the related statutory statements of revenues and expense, changes in capital and surplus, and cash flows for the calendar year.	As specified by State
Onsite Review	Annually	Annual onsite review of Contractor by State staff and may include oversight of Contractor Personnel staffing, Credentialing, Utilization Management, Quality Improvement, Care Coordination with other Systems, Care Coordination with Special Health Care Needs Clients, Care Coordination with Medical Providers, General Info and Member Outreach.	April

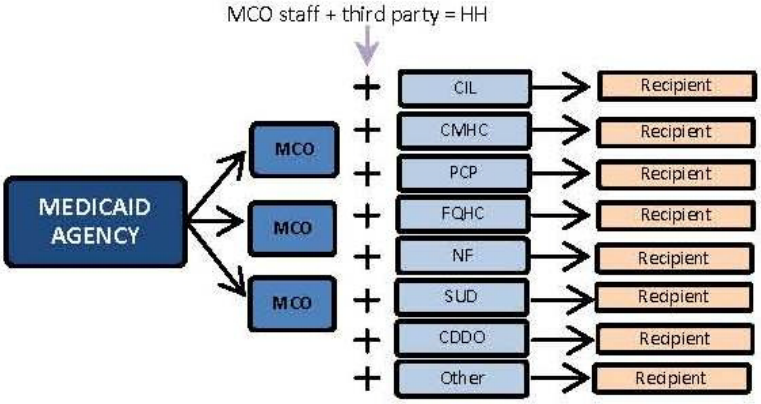
Name of report	Reporting frequency	Report description	Report Due to State
Department of Insurance Filings Audit Report	Quarterly & Annually	This is a Department of Insurance report to the State of Kansas Insurance Department and the Medicaid agency	Monitor when submitted
Utilization of Services Report	Quarterly, three months in arrears	By service, unduplicated # members receiving services, mean hours per member, mean service units per member, and mean reimbursement per member. Data is reported by catchment area and statewide and by ages 0-17 and 18+.	As specified by the State
SED Waiver Requested Services and Service Delivery by Dates of Service Report	Quarterly, three months in arrears	# of requested and provided (not necessarily paid) units of service for SED Waiver services. Data is reported by specific SED Waiver service.	As specified by the State
SED Waiver Frequency of Services by Dates of Service Report	Quarterly, three months in arrears	# of registrations, # of SED Waiver members with a service, % of SED Waiver members receiving a service. Data is reported by catchment area and statewide.	As specified by the State
Members Presenting for Screen with Previous Service (30 days prior to screen) Report	Quarterly, three months in arrears	# of screens, # admitted, # diverted, members with screen, % of members receiving a service 30 days prior to screen date	As specified by the State
Alternative Community Plan (Diversion) Follow-up Services Report	Quarterly, three months in arrears	# requiring follow-up services, % receiving services within 72 hours of development of alternative community plan (diversion)	As specified by the State
SED Waiver Member Outcome Indicators Report	Quarterly	Outcome indicators include: Permanent Family Home, Regular School Attendance, Without Law Enforcement Contact, A, B or C grades in School, Significant CBCL scores for children/youth receiving SED Waiver services. Data is reported by CMHC and statewide	As specified by the State
SED Waiver Psychiatric Screens Report	Quarterly	Psychiatric Screens: Admissions and Diversions for children/youth receiving SED Waiver services. Data is reported by CMHC and statewide.	As specified by the State
SED Waiver Grievance Summary and Trends	Quarterly	Grievances reported involving children/youth receiving SED Waiver services. Data is reported by CMHC and statewide	As specified by the State
SPMI and SED Member Outcome Indicators Report	Quarterly	Outcome indicators include Permanent Family Home, Regular School Attendance, Without Law Enforcement Contact, A, B or C grades in School, Significant CBCL scores, Post-Secondary Education (SPMI).	As specified by the State

Name of report	Reporting frequency	Report description	Report Due to State
Percentage of CBST Reviews Completed within Established Timeframe Report	Quarterly	# of CBST meetings, # and % completed in fewer than 7 days, # and % completed in greater than 7 days. Separate tables for initial, extension, and exception meetings. Standard: 95% of CBST meetings are completed in fewer than 7 days.	As specified by the State
Alternative Community Plans (Diversions) from Inpatient Care Report	Quarterly	Separate reports for Inpatient psychiatric and PRTF facility types. Total assessments, total admissions and diversions, and % of assessments leading to a diversion. Data is reported by catchment area and statewide.	As specified by the State
Discharge to Homelessness Report	Quarterly	By month, # of inpatient discharges, # and %, (less than 3% for Adults, 1.5% for children) of discharges to homelessness. One table for children/youth 0-17 and one for adults. Each discharge to homelessness should be accompanied by an explanation as to why it occurred.	As specified by the State
Inpatient Discharges to Community Report	Quarterly	# and % discharged to home/family/friend, foster home, nursing home, and group home. Discharges are tracked from the following facility types: PRTF, state hospitals, inpatient psychiatric facilities, and state hospital alternatives. Discharges are not exclusive to mental health contract. Data is reported by catchment area and statewide.	As specified by the State
Evidence-Based Practice Fidelity Report (for sites with evidence-based practice programs)	Quarterly	Most recent fidelity review date, date program met fidelity for enhanced rate; date decertified and recertified, and date next fidelity review due by CMHC.	As specified by the State
All Members Penetration Rate Report	Annually	Total members served, % to Total Medicaid population, Penetration rate per 1,000 KHS members and per 10,000 Kansas population. Data is reported by catchment area.	As specified by the State
Member Penetration Rates to Medicaid Population by Diagnostic and Service Categories by Dates of Service Report	Annually	Diagnostic and service categories include: total members, total SED Waiver members, total non-English speaking members, total dual diagnosis (SUD and MH) members, total dual diagnosis (MR/DD and MH) members, Total SPMI members, total outpatient mental health members, total outpatient medication management services members. Data is reported by catchment area and statewide.	As specified by the State
Member Penetration Rates to Kansas Estimated U.S. Population by Diagnostic and Service Categories by Dates of Service Report	Annually	Diagnostic and service categories include: total members, total SED Waiver members, total non-English speaking members, total dual diagnosis (SUD and MH) members, total dual diagnosis (MR/DD and MH) members, Total SPMI members, total outpatient mental health members, total outpatient medication management services members. Data is reported by catchment area and statewide.	As specified by the State

Name of report	Reporting frequency	Report description	Report Due to State
Summary of Quality Management Activities Report	Annually	Youth Focused Study Program Improvement Plan, Adult Focused Study Program Improvement Program	As specified by the State
Network Analysis of Providers by Agency Report	Annually	Net % change in number of licensed mental health practitioners at the end of the fiscal year compared to the same percentage at the end of the prior fiscal year.	As specified by the State
Network Analysis of Certified Providers Report	Annually	# participating in specific service online courses by course name; peer support training, and interactive community event (ICE) training. Separate reports for individual training contractor.	As specified by the State
Medicaid Waiver Report	Quarterly	Quarterly report used by Management Operations to report federal spending to KDHE-DHCF. Report includes the utilization (total units and dollars by month) for all Medicaid members who had Reintegration or Intermediate services (b3 services) paid since the beginning of the contract. Unique members are unduplicated by month. Each new quarter is added to the end of the report. Data is reported by the date in which the service was paid.	As specified by the State
Dashboard report	Monthly	Fiscal and Utilization Dashboard reports of the managed care CONTRACTOR(S) for SRS Management. Utilization report includes trending graphs of higher and lower levels of care admissions, higher levels of care average length of stay, unique members served, Medicaid penetration rates, higher levels of care male and female readmissions and access to care for urgent, routine and IV Drug Users. Fiscal dashboard to be determined.	As specified by the State

ATTACHMENT I
Kansas Health Homes (HHs) Model

The diagram[1] below illustrates the relationship between the Managed Care Organization (MCO) and various other providers who will form HHs for members with chronic conditions identified in the Center for Medicare and Medicaid Services (CMS) State Medicaid Directors Letter # 10-024.



The MCO must develop a detailed description of how it will provide HHs, including how it will address the following components:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services;
- Coordinate and provide access to high-quality healthcare services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders (SUD);
- Coordinate and provide access to mental health (MH) and SUD services;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient (IP) and community based residential or other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care (LTC) supports and services;
- Develop a person-centered care plan for each individual that coordinates and integrates all of his/her clinical and non-clinical health-care related needs and services;
- Demonstrate a capacity to use health information technology (HIT) to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate;
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level; and
- Clearly delineate what the CONTRACTORS' responsibilities vs. providers, members and family members responsibilities are in this model.

  In addition the description should include what activities and tasks are needed from Kansas Department of Health and Environment (KDHE)/DHCF or other State agencies to successfully provide a HH.

[1]Adapted from Hasselman, Dianne and Bachrach, Deborah. (June 2011). Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System. Center for Health Care Strategies, Inc.

ATTACHMENT K
Encounter Data and Other Data Requirements

1.0 Encounter Data

The CONTRACTOR shall collect service information in the federally mandated Health Insurance Portability and Accountability Act (HIPAA) transaction formats and code sets, and submit this data in a standardized format approved by the State. The CONTRACTOR must make all collected data available to the State after it is tested for compliance, accuracy, completeness, logic, and consistency. The CONTRACTOR(S) shall follow the encounter data protocol provided in this Attachment and Appendix 1 — MCO Data Submission Manual.

1.1 Compliance with HIPAA-Based Code Sets

The CONTRACTOR systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed:

1.1.1

Health Care Common Procedure Coding System (HCPCS)- This code set, established and maintained by the Centers for Medicare & Medicaid Services (CMS), primarily represents items and supplies and non-physician services not covered by the American Medical Association Current Procedure Terminology (CPT)-4 codes. This file does not contain the CPT-4 codes. CPT-4 codes can be purchased from the American Medical Association at 1-800-621-8335.

1.1.2

CPT codes- The CPT-4 codes are used to describe medical procedures and physicians services, and is maintained and distributed by the American Medical Association (AMA). For more information on the CPT-4 codes, please contact the AMA.

1.1.3

International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

1.1.4

International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

1.1.5

International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2013.

1.1.6

National Drug Codes (NDC)- The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

1.1.7

Code on Dental Procedures and Nomenclature (CDT)- The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

1.1.8

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintain point of service (POS) codes used throughout the health care industry.

1.1.9

Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

1.1.10

Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the medicaid management information system (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

NOTE - Professional and institutional claims contain CARC and RARC codes, while pharmacy claims contain NCPDP reject codes. RARCs are used in conjunction with CARCs to further explain a payment decision or to relay additional information. NCPDP reject codes are used to document other insurance denial reasons for pharmacy claims.

1.2 Compliance with Other Code Sets

CONTRACTOR systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:

1.2.1

As described in all State Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format).

1.2.2

As described in all State Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

1.3 Encounter Data Submission Standards

1.3.1

The CONTRACTOR shall have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:

1.3.1.1

All CONTRACTOR encounters shall be submitted to the State or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format. Health Plan paid amounts shall be provided.

1.3.1.2

The CONTRACTOR shall collect, and submit to the State‘s fiscal agent, enrollee service level encounter data for all covered services. The CONTRACTOR shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on their behalf.

1.3.2

The CONTRACTOR shall conform to HIPAA-compliant standards for information exchange effective the first day of operations. Batch and Online Transaction Types are as follows:

1.3.2.1

Batch transaction types

1.3.2.1.1

ASC X12N 820 Premium Payment Transaction

1.3.2.1.2

ASC X12N 834 Enrollment and Audit Transaction

1.3.2.1.3

ASC X12N 835 Claims Payment Remittance Advice Transaction

1.3.2.1.4

ASC X12N 837I Institutional Claim/Encounter Transaction

1.3.2.1.5

ASC X12N 837P Professional Claim/Encounter Transaction

1.3.2.1.6

ASC X12N 837D Dental Claim/Encounter Transaction

1.3.2.1.7

NCPDP D.0 Pharmacy Claim/Encounter Transaction

1.3.2.2

Online transaction types

1.3.2.2.1
ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
1.3.2.2.2
ASC X12N 276 Claims Status Inquiry
1.3.2.2.3
ASC X12N 277 Claims Status Response
1.3.2.2.4
ASC X12N 278/279 Utilization Review Inquiry/Response
1.3.2.2.5
NCPDP D.0 Pharmacy Claim/Encounter Transaction

1.3.3
The CONTRACTOR shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

The transaction and code sets can be found at www.cms.gov.

1.4 Encounter Data Completeness, Accuracy, Timeliness, and Error Resolution
The CONTRACTOR(S) shall provide complete and accurate encounters to the State. The CONTRACTOR(S) shall implement review procedures to validate encounter data submitted by providers. The following standards are hereby established:
1.4.1
Completeness
A CONTRACTOR must be submitting encounters that represent at least 98% of the covered services provided by the Health Plan network and non-network providers. The CONTRACTOR shall strive to achieve a 100% complete submission rate. All data submitted by the providers to the CONTRACTOR must be included in the encounter submissions.
1.4.2
Accuracy
1.4.2.1
Transaction type (X12): 98% of the records in a CONTRACTOR's encounter batch submission pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The X12 electronic data interface (EDI) compliance edits are established through strategic national implementation process (SNIP) levels 1 through 4. MMIS threshold and repairable edits that report exceptions are defined in the Encounter Data Submission Guide (Appendix 1).
1.4.2.2
Transaction type (NCPDP): 98% of the records in a CONTRACTOR's encounter batch submission pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP Telecommunications Standard Guides. Pharmacy benefits system threshold and repairable edits that report exceptions are defined in the Encounter Data Submission Guide (Appendix 1).
1.4.3
Timeliness
Encounter data shall be submitted weekly, and within five (5) working days of the end of each weekly period and within 30 days of claim payment. All encounters must be submitted, both paid and denied claims. The paid claims must include the CONTRACTOR paid amount.
1.4.4
Error resolution
1.4.4.1
For all encounters submitted after the submission start date, including historical and ongoing claims, if the State or its fiscal agent notifies the CONTRACTOR of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the CONTRACTOR shall remediate all such encounters within 30 calendar days after such notice. Failure to do so could result in a corrective action plan (CAP) or liquidated damages as specified in Attachment G.

1.4.4.2
Encounters cannot be adjusted, therefore they must be updated through the Void and Replacement process. (See process described in the MCO data submission Manual starting on page 38). Encounters must be voided and a replacement sent within 30 days of identifying that the original encounter was in error.
1.4.5
The CONTRACTOR shall participate in State-sponsored workgroups directed at continuous improvements in encounter data quality and operations. For additional information regarding Encounter Data submission, please reference the Encounter Data Submission Guide (Appendix 1).

1.5 Eligibility and Enrollment Data Exchange Requirements
1.5.1
Provider Roster
The CONTRACTOR shall receive a member roster once per month with daily updates. The CONTRACTOR shall update its eligibility/enrollment databases within 24 hours after receipt of said files. The CONTRACTOR shall transmit to the State or its agent, in a periodicity schedule, format and data exchange method to be determined by the State, specific data it may garner from an enrollee, including third party liability (TPL) data.

1.6 Information Management and Systems
The following system requirements shall be met by the CONTRACTOR:

1.6.1
Availability of Critical Systems Functions
The CONTRACTOR shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available 24 hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the State and the CONTRACTOR. Unavailability caused by events outside of the CONTRACTOR's span of control is outside the scope of this requirement. The CONTRACTOR shall make the State aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.

1.6.2
Availability of Data Exchange Functions
The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with the State and/or its agent(s) are available and operational according to specifications and the data exchange schedule.

1.6.3
Availability of Other Systems Functions
The CONTRACTOR shall ensure that at a minimum all other system functions and information is available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.

1.6.4
Problem Notification
1.6.4.1
Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the CONTRACTOR and the State and/or its agent(s), the CONTRACTOR shall notify the applicable State staff via phone, fax and/or electronic mail within one (1) hour of such discovery. In its notification, the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes.
1.6.4.2

The CONTRACTOR shall provide to appropriate State staff information on system unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

1.6.5
Recovery from Unscheduled System Unavailability
Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control will be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.

1.6.6
Exceptions to System Availability Requirement
The CONTRACTOR shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CONTRACTOR's span of control.

1.6.7
Information Systems CAP
If at any point there is a problem with a critical systems function, at the request of the State, the CONTRACTOR shall provide to the State full written documentation that includes a CAP that describes how problems with critical systems functions will be prevented from occurring again. The CAP shall be delivered to the State within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the CONTRACTOR subject to liquidated damages.

1.6.8
Business Continuity, Risk Management and Disaster Recovery Plan
The CONTRACTOR shall provide to the State within 90 days following contract award the Business Continuity, Risk Management and Disaster Recovery plans. Regardless of the architecture of its systems, the CONTRACTOR shall develop, and be continually ready to invoke, a business continuity, risk management, and disaster recovery plan that is reviewed and prior-approved by the State. If the approved plan is unchanged from the previous year, the CONTRACTOR shall submit each year, a certification to the State that the prior year's plan is still in place. This certification must be submitted on or before the CONTRACTOR's contract anniversary. Changes in the plan are due to State within 10 business days after the change. Additionally, all data associated with this contract and other contract documents and records must be protected against hardware and software failures, human, error, natural disasters, and other emergencies which could interrupt services.
1.6.8.1
Risk Management should address the CONTRACTOR's identified risks and their proposed solution or action to be taken to alleviate or minimize the consequences in the event that those risks become actuality.
1.6.8.2
Business Continuity should encompass Risk Management, Disaster Recovery, as well as providing additional analysis of the impact of potential risks, disasters, and so on. Further, it should address personnel replacement plans, both short term and long term. At a minimum, the CONTRACTOR's plan shall address the following:
1.6.8.2.1
Recovery of business functions, business units, business processes, human resources, and technology infrastructure.
1.6.8.2.2
Identify core business processes
1.6.8.2.2.1
Identification of potential system failures for the process
1.6.8.2.2.2
Risk analysis
1.6.8.2.2.3
Impact analysis

1.6.8.2.2.4
Definition of minimum acceptable levels of outputs
1.6.8.2.2.5
Documentation of contingency plans
1.6.8.2.2.6
Definition of triggers for activating contingency plans
1.6.8.2.2.7
Discussion of establishment of a business resumption team
1.6.8.2.3
Maintenance of updated disaster recovery plans and procedures that include, but not limited to:
1.6.8.2.3.1
Central computer installation and resident software are destroyed or damaged
1.6.8.2.3.2
System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage
1.6.8.2.3.3
System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system
1.6.8.2.3.4
System interruption or failure resulting from network, operating hardware, software or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, (i.e. cause unscheduled system unavailability)
1.6.8.2.4
Plan for replacement of personnel
1.6.8.2.4.1
Replacement in the event of loss of personnel before or after signing this contract
1.6.8.2.4.2
Replacement in the event of inability by personnel to meet performance standards
1.6.8.2.4.3
Allocation of additional resources in the event of the CONTRACTOR's inability to meet performance standards
1.6.8.2.4.4
Replacement/addition of personnel with specific qualifications
1.6.8.2.4.5
Timeframes necessary for replacement
1.6.8.2.4.6
CONTRACTOR's capability of providing replacements/additions with comparable experience
1.6.8.2.4.7
CONTRACTOR shall ensure that quality of service is not compromised by excessive staff turnover
1.6.8.2.4.8
Process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the contract, including the State's role in getting the replacement personnel
1.6.8.2.4.9
Replacement of staff with key qualifications and experience with new staff with similar qualifications and experience
1.6.8.3
The CONTRACTOR shall periodically, but no less than annually, on or before the CONTRACTOR's contract anniversary, of each contract year, perform comprehensive tests of its plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore system functions per the standards outlined in the contract.

In the event that the CONTRACTOR fails to demonstrate in the tests of its plan that it can restore system functions per the standards outlined in this contract, the CONTRACTOR shall be required to submit to the State a CAP in accordance with Section 2.3.4.2, that describes how the failure will be resolved. The CAP shall be delivered within 10 business days of the conclusion of the test.

1.6.9
Notification and Discussion of Potential System Changes
The CONTRACTOR shall notify the State of the following changes to systems within its span of control at least 90 calendar days before the projected date of the change. If so directed by the State, the CONTRACTOR shall discuss the proposed change with the applicable State staff. This includes:
1.6.9.1
software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management;
1.6.9.2
conversions of core transaction management systems; and
1.6.9.3
new system implementations.

1.6.10
Response to State Reports of Systems Problems Not Resulting in System Unavailability
The CONTRACTOR shall respond to State reports of system problems not resulting in system unavailability according to the following timeframes:
1.6.10.1
Within seven (7) calendar days of receipt, the CONTRACTOR shall respond in writing to notices of system problems.
1.6.10.2
Within 20 calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
1.6.10.3
The CONTRACTOR shall correct the deficiency by an effective date to be determined by the State.

1.6.11
Valid Window for Certain System Changes
Unless otherwise agreed to in advance by the State as part of the activities described in this section, scheduled system unavailability to perform system maintenance, repair and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

1.6.12
Testing
The CONTRACTOR shall work with the State pertaining to any testing initiative as required by the State. Upon the State's written request, the CONTRACTOR shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the State to corroborate the readiness of the CONTRACTOR's information systems.

1.7 Documentation Requirements
1.7.1
Types of Documentation
The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals and quick-reference guides, and any updates thereafter, for the State and other applicable State staff. The CONTRACTOR shall provide this documentation in outline form electronically for approval by the State.
1.7.2
Content of System Process and Procedure Manuals
The CONTRACTOR shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
1.7.3
Content of System User Manuals
The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.
1.7.4

Changes to Manuals
When a system change is subject to the State's written approval, the CONTRACTOR shall draft revisions to the appropriate manuals prior to State approval of the change. Updates to the electronic version of these manuals shall occur in real time.
1.7.5
Availability of/Access to Documentation
All of the aforementioned manuals and reference guides shall be available electronically and on-line. If so prescribed, the manuals will be published in accordance with the appropriate State and/or Federal standard. Additionally, the documentation shall be provided in printed form upon request.

1.8 Encounter Data - Staffing Requirements
1.8.1
Claims/Encounter Manager: The CONTRACTOR shall have a designated person qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness and completeness of processing payment and reporting.
1.8.2
The CONTRACTOR shall designate sufficient resources to perform these encounter functions as determined by generally accepted best industry practices.

2.0 Other Requirements

2.1 Methods for Data Exchange
The CONTRACTOR and the State and/or its agent shall make predominant use of secure file transfer protocol (SFTP) and EDI in their exchanges of data.

2.2 State-Based Formatting Standards and Methods
CONTRACTOR systems shall exchange the following data with the State and/or its agent in a format to be jointly agreed upon by the CONTRACTOR and the State:
2.2.1
Provider network data: The CONTRACTOR shall submit provider information electronically to the fiscal agent in a provider roster format approved by the State. This information will be updated monthly by the CONTRACTOR and will be a full file replacement each month
2.2.2
Case management fees, if applicable
2.2.3
Payments
2.2.4
Member and services data: CONTRACTOR(S) must report separately on those Members receiving care for chronic behavioral health conditions (i.e. SPMI, SUD etc.), disabilities (i.e. DD, PD, TBI etc.), long term care (LTC) services and physical health services. CONTRACTOR(S) must also report separately on services including but not limited to outpatient (OP) behavioral health services and inpatient (IP) behavioral health services.
2.2.5
Pharmaceutical Report
The CONTRACTOR (or their subcontractors) shall report all pharmacy data in an NCPDP format in the event that the CONTRACTOR utilizes a Pharmacy Benefit Manager and pharmacy data is not included in the encounter data. The CONTRACTOR shall also provide claims summary reports, drug utilization review (DUR) reporting and also a yearly pharmacy program summary. This includes utilization, expenditures, trend reporting, spending by types of medications, etc.
2.2.6
Mental Health (MH) Outcomes Data
The CONTRACTOR(S) (and/or their subcontractors) shall report all MH outcomes data in compliance with the automated information management system (AIMS) data collection requirements. The CONTRACTOR shall also provide summary and detail reports on data completeness and accuracy, as defined in the AIMS manual.

2.3 Substance Use Disorder (SUD) Data System Requirements

The CONTRACTOR(S) shall work with the Kansas Client Placement Criteria (KCPC) or other SUD specific data system/data collection tool. This tool incorporates the American society of addiction medicine (ASAM) criteria and must be used in making SUD service authorization decisions. The State will monitor both the CONTRACTOR(S)' application and documentation of the Kansas definition of medical necessity and the ASAM criteria as contained in the KCPC system through ongoing reviews including, but not limited to, external audits. The CONTRACTOR(S) confirms it will document all authorizations and any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than the request in the CONTRACTOR's records and that documentation shall reference the Kansas medical necessity definition and ASAM criteria as contained in the KCPC system. The CONTRACTOR(S) information systems must be compatible or will become compatible with the KCPC system used by providers in Kansas. The CONTRACTOR shall ensure that it as well as its subcontracted providers uses the required Kansas medical necessity definition, ASAM criteria as contained in the KCPC system for determination of level of service, even when prior authorization (PA) from the CONTRACTOR is not required.

2.4 Data Certifications

Data submitted by the CONTRACTOR including, but not limited to, all documents specified by the State, enrollment information, encounter data, and other information required as a deliverable in the contract, must be certified. The Attestation Form shall include the following:

2.4.1

Authority to Certify. All data and documents requiring certification the CONTRACTOR submits to the State shall be certified by one of the following:

2.4.1.1

CONTRACTOR's Chief Executive Officer

2.4.1.2

CONTRACTOR's Chief Financial Officer

2.4.1.3

An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR's Chief Executive Officer or Chief Financial Officer.

2.4.2

Content of Certification: The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.

2.4.3

Timing of Certification: The CONTRACTOR must submit the certification concurrently with the certified data and documents.

2.4.4

Data Specifications: Include the complete file name, the file size, and the date range of the contained in the submitted file.

MCO Data Submission Manual

MCO Data Submission Manual

REVISED: DECEMBER 2, 2010

VERSION 5.6

Address any comments concerning the contents of this manual to:
HP Enterprise Services
Managed Care Encounter Data
P. O. Box 3571
Topeka, KS 66601-3571
Telephone: 785-274-4200
Fax: 785-267-7687

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 4.3	04/27/2007	Full Manual	New formatting, process clarifications	
Version 4.4	06/02/2007	Page 11	Field Name – Trailer Total Changes	
Version 4.5	06/08/2007	Page 2 Page 3 Page 8	1.a Third bullet, MCO Medicaid Number and Srv Location Provider Social Security Number	
Version 4.6	06/25/2007	Pages 4, 5 Page 6 Page 9 Page 10 Page 11 Page 12	Naming Conventions Formatting Guidelines Provider Name Indicator, Provider Name Filler Trailer Total Changes Error File Layout	
Version 4.7	09/18/2007	Page 4 Page 6 Page 8 Pages 10, 11 Pages 19, 20 Pages 23-32	PR1 Request File File Layouts File Layout Updates Provider Specialty Codes Provider Type, Specialty, and Taxonomy	
Version 4.8	08/05/08	Page 1 Pages 2, 3 Page 4 Page 5 Page 5 Page 12 Page 13 Page 20 Pages 25, 29	Introduction PR1 Process Naming Conventions, File Transfer, and Folder Structure Initial and Weekly Provider File Layouts Provider Weekly File Detail Record PR1 Error File Layout PR1 NPI Addition E-mail Report Layout Provider Specialty Codes Provider Type, Specialty, and Taxonomy	Greg Wallace
Version 4.9	08/15/08	Page 4	Naming Conventions	Greg Wallace
Version 5.0	10/5/09	Full Manual	Incorporated multiple documents into one,	Greg Wallace

			including the PR1 Companion Guide (Appendix 1) Added KM1 file processes Added KM1 file layout (Appendix II) Added updates to the PR1 file layout Removed recommended fields section Added Unsolicited 277 section Added POA section Updated Code Tables in Appendix I Added NEMT broker information. Active Indicator Description Provider Enrollment Indicator field added Reduced size of filler Updated all code tables	
Version 5.1	06/03/10	Full Manual	Added new error code E795 (CO11951) Replaced all references of EDS to HP Updated the email address for the MCO Liaison distribution list. Changed the email address for Provider Enrollment. Added information on KMAP response files Added contact information under section 2. PRVLST file layout updated on the formatting of the Provider Name. PR1 Request file layout updated on the formatting of the Provider Name. Removed all references to the Record Change Indicator of "C"	Joyce Dillon
Version 5.2	06/14/10	Full Manual	Detail Record requirements updated on the PR1 Request File	Joyce Dillon

			layout (MCO Assigned Number)	
Version 5.3	0713/10	Full Manual	Added clarification for the Other1 and Other2 Provider fields in the KM1 file layout.	Joyce Dillon
Version 5.4	08/02/10	Full Manual	Added a clarification for the ZIP-code requirements on the PR1 Request File layout.	Joyce Dillon
Version 5.5	09/10/10	Full Manual	Merged the revision history from appendix 1 into the revision history for the entire manual. Section 3: Clarification added for Pharmacy claims and the KM1.Section 4: Clarification added on the void and replace process. Section 5: Clarifications added on unsolicited 277 responses. Section 7: Clarifications added on the PR1 process. Appendix I: Naming convention requirements were added for encounter files. Daily and monthly roster information was added. Appendix II: Updated the Claim_Detail_Number field description in the KM1 file layout section. Added information regarding pharmacy processing with the KM1 for duplicate encounters. The following provider ID's in the KM1 file layout have been referenced to the corresponding loops on the 837: BILLING_PROVIDER_KMAP_BASE PERF_PROVIDER_KMAP_BASE REFER1_PROVIDER_KM	Joyce Dillon

			AP_BASE REFER2_PROVIDER_KMAP_BASE ATTEND_PROVIDER_KMAP_BASE OTHER1_PROVIDER_KMAP_BASE OTHER2_PROVIDER_KMAP_BASE FACILITY_PROVIDER_KMAP_BASE PRESCRIBER_PROVIDER_KMAP_BASE	
Version 5.6			Appendix III: Added MCO Submission Checklist with hyperlinks to reference material on encounter submission requirements. Added examples of the naming conventions for each file type and their corresponding KM1 file. Reformatted Manual to Business Practice Manual standard format.	Joyce Dillon
Version 5.6	12/2/10	Full Manual	Complete Manual overhaul; sent to KHPA for approval on 12-2-10.	Jenn Tibbits

Table of Contents

Overview

The Managed Care Organization (MCO) Data Submission Manual is the working document for the MCO's. The purpose of this manual is to provide direction for both new and established MCO's in coordinating the submission of encounter data so that it is accepted and properly processed by the interChange MMIS system.

This document will cover these main topics:

- Provider Enrollment Process (PR1) process
- Encounter Submission Process (837 file)
- KMAP ID/Service Location Match Process (KM1) file
- Void and Replacement Process
- Encounter Claim Response Information
- Eligibility Roster
- Encounter Data Attestations
- Tips and Troubleshooting

It is important to understand that these processes are inter-related and inter-dependant. If one fails, all will fail.

Section 2: ***Provider Enrollment Process (PR1)***

PR1 Process

Initial Provider Enrollment Process (PR1) Setup

The initial PR1 setup is the most crucial step in the whole encounter process. This section will explain the initial PR1 process from beginning to end in a step by step format.

Provider List File (PRVLST)

The PRVLST file is a file of the Medicaid providers (both active and inactive) and PR1 providers (active only). Kansas Medical Assistance Program (KMAP) uses File Transfer Protocol (FTP) to send the PRVLST to a predefined folder on the MCOs FTP server. This is the first step in creating the MCO Provider Request File (PR1 file). The MCOs use the PRVLST file to build their initial PR1 file. The file layout for the PRVLST file is located in Appendix A.

The PRVLST file name and predefined folder name is illustrated below:

Naming Convention	**Folder Name**
F.<SAK>.<MCO Medicaid Number>.PRVLST.<YYMMDDhhmmss>.dat PRVLST indicates Provider Listing file *(i.e. F.390663.299999999A.PRVLST.070608190000.dat)*	Provider_FullListing

Provider Request File (PR1 file)

The MCO reviews the data on the PRVLST file and attempts to match their providers to a KMAP provider to build their initial PR1 file. When trying to determine if a provider on the PRVLST file is a match to a provider in your MCO network the following criteria should be considered:

- National Provider Identifier (NPI)
- Employer Identification Number (Tax ID)
- Provider Name
- Provider Address
- Provider Type
- Provider Specialty
- Social Security Number (SSN) or License Number (if submitted in the request file)

Adding providers or adding MCO program eligibility:

When determining which KMAP ID/Service Location (KMAP ID/SL) to activate for your MCO provider eligibility, the following logical progression must be followed. Please be sure to refer to the end of the PR1 section for the PR1 Program Specific Instructions for your MCO:

1. Active KMAP ID/SL combination with Medicaid program eligibility
2. Active KMAP ID/SL combination PR1 number with another MCO
3. Inactive KMAP ID/SL combination with Medicaid program eligibility
4. Create new number through the add process

The first four options must always be exhausted before creating a new KMAP ID/SL through the add process.

Note: A valid KMAP ID/SL is a 10 digit number, the first 9 are numeric values followed by an alpha character.

There are indicators on the PRVLST file that will assist the MCOs with the hierarchy listed above.

Medicaid Indicators:

- **M** – If the Medicaid indicator is an 'M', this means the provider has or has had Medicaid eligibility.
- **N** – If the Medicaid indicator is an 'N', this means that the provider has never had Medicaid eligibility.

Active Indicators:

- **M** – An indicator of M means the provider is active for you. In other words, a PR1 request record has previously been sent in and program eligibility for the MCO already exists. If you find this provider is a match, no further action is needed.
- **C** – An indicator of C means the provider has active MCO program eligibility, but not for you. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **O** – An indicator of O means the provider has one or more MCO program eligibility records, but they are all inactive. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **A** – An indicator of A means the provider is an active Medicaid provider and there are no MCO program eligibility records, active or inactive. If

you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.

- **I** – An indicator of I means the provider is an inactive Medicaid provider and there are no MCO program eligibility records, active or inactive. If you find this provider is a match, a PR1 request records would need to be submitted to activate program eligibility for you.
  Note: This would only apply to the MCOs that are not required to map to an active Medicaid provider.

If a match **is found** on the PRVLST file, the MCO updates the mandatory fields on the PR1 record and marks the record change indicator as 'A' to add their MCO eligibility to the specified KMAP provider. Please keep in mind the KMAP ID/SL **must** be included in the request. Refer to the PR1 Request File layout in Appendix A for the mandatory fields.

Note: If the MCO is mapping to an existing Medicaid Provider, it is essential to make sure all of the information matches for the MCO. For instance, on existing Medicaid providers the MCOs can not add a new specialty to the Medicaid provider. If the specialty for the MCO does not match to the existing Medicaid provider then the next process should be followed for if a match is not found.

If a match **is not found** on the PRVLST file, the MCO marks the record change indicator as 'A' and fills out all of the mandatory fields as indicated in the PR1 Request File layout in Appendix A. Please keep in mind when performing this task a KMAP ID/SL would **not** be included in the request. This process will create a new KMAP ID/SL. This occurs when a provider in the MCO network is **not** found in the PRVLST file, meaning the MCO provider is not a KMAP provider.

In either case, whether mapping to an existing provider or requesting to add a new one, the 'A' indicator must be used.

The MCO may send updates to any of the PR1 fields; however, only the following fields are updated in the MMIS:

- Record Type
- Record Change Indicator
- MCO Medicaid Number
- MCO Service Location
- Provider Start Date
- Provider End Date
- PAR/Non-PAR

Note: After the initial PR1 activation, providers should only be added to the process as services are provided by that provider to KMAP eligible beneficiaries

or if a provider joins your MCO that is actively providing services to KMAP eligible beneficiaries. These updates will follow the Weekly PR1 process as outlined in the next subsection.

Deleting providers:

During your initial PR1 process ***and*** when using the PRVLST file as the source file for creation of the PR1 Request file, **all** other providers on the PRVLST file that are **not** being added or activated for your MCO must be deleted from the file.

NOTE: Medical, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP) MCOs, and Non Emergency Medical Transportation Brokers (NEMT) doing their initial PR1 provider load **MUST NOT** load their entire provider database. There are tens of thousands of providers in some MCO networks that will never provide services to a KMAP eligible beneficiary. During the initial PR1 provider activation, only MCO providers that match the first three conditions in the matching criteria should be added as eligible MCO providers.

Failure to follow this process will create unneeded providers that extend the PRVLST and create confusion when adding new MCO providers through the PR1 request process.

Once the MCO has completed the add and delete processes outlined above and have a finalized initial PR1 file, the MCO then sends this file back to KMAP by copying the file to a predefined folder on the MCOs FTP server. The KMAP EDI jobs, which consists of 5 jobs per submitter, picks up the files from that folder every 15 minutes and transfers the file(s) to the MMIS servers for processing. KMAP processes the PR1 request file from the MCOs once every week on Monday night at 7 p.m. and generates response and error files.

The PR1 Request file name and predefined folder name is illustrated below:

PR1 Request File Naming Convention	Folder Name
HW<19 or 21>_<MCO Medicaid Number>_PR1_<YYMMDDhhmmss>.dat PR1 indicates PR1 request file *(i.e. HW21_299999999A_PR1_070608190000.dat)*	Provider_Request

PR1 Response File (PRRP)

KMAP generates the PRRP file after the PR1 Request file has been processed. The PRRP file contains the KMAP ID/SL that has been assigned to the newly added Medicaid Providers. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRRP file is located in Appendix A.

The PRRP file name and predefined folder name is illustrated below:

PR1 Response File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRRP.<YYMMDDhhmmss>.dat PRRP indicates PR1 response file *(i.e. F.390663.299999999A.PRRP.070226210420.dat)*	Provider_Response

PR1 Error File (PRER)

KMAP generates the PRER file after the PR1 Request file has been processed. The PRER file returns information to the MCOs regarding PR1 records that failed the PR1 Request process. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRER file is located in Appendix A.

The PRER file name and predefined folder name is illustrated below:

PR1 Provider Error File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRER.<YYMMDDhhmmss>.dat PRER indicates PR1 provider error file *(i.e. F.390663.299999999A.PRER.070226210420)*	Provider_Error

Weekly PR1 Process

Once the MCOs have completed the initial PR1 activiation, KMAP sends a weekly PRVLST file every Thursday at 12:00 a.m.. The weekly PRVLST file must be used by the MCOs to maintain their PR1 file built with the initial PR1 process. This can be accomplished by creating 'add' records for any new provider that has joined the MCO network or adding the MCO eligibility to any new KMAP providers. The MCO can also perform 'delete' records to remove or end date MCO program eligibility from providers. The file layout for the PRVLST file is located in Appendix A.

PR1 File:

The MCO reviews the data on the PRVLST file and attempts to match their providers to a KMAP provider. When trying to determine if the provider on the PRVLST file is a match to a provider in the MCO network, the following criteria should be considered:

- NPI
- Tax ID
- Provider Name
- Provider Address
- Provider Type
- Provider Specialty

- SSN or License Number (if submitted in the request file)

Adding providers or adding MCO program eligibility:

When determining which KMAP ID/Service Location (KMAP ID/SL) to activate for your MCO provider eligibility, the following logical progression must be followed Please be sure to refer to the end of PR1 section for the PR1 Program Specific Instructions for your MCO:

1. Active KMAP ID/SL combination with Medicaid program eligibility
2. Active KMAP ID/SL combination PR1 number with another MCO
3. Inactive KMAP ID/SL combination with Medicaid program eligibility
4. Create new number through the add process

The first four options must always be exhausted before creating a new KMAP ID/SL through the add process.

Note: A valid KMAP ID/SL is a 10 digit number, the first 9 are numeric values followed by an alpha character.

There are indicators on the PRVLST file that will assist the MCOs with the hierarchy listed above.

Medicaid Indicators:

- **M** – If the Medicaid indicator is an 'M', this means the provider has or has had Medicaid eligibility.
- **N** – If the Medicaid indicator is an 'N', this means that the provider has never had Medicaid eligibility.

Active Indicators:

- **M** – An indicator of M means the provider is active for you. In other words, a PR1 request record has previously been set in and program eligibility for the MCO already exists. If you find this provider is a match, no further action is needed.
- **C** – An indicator of C means the provider has active MCO program eligibility, but not for you. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **O** – An indicator of O means the provider has one or more MCO program eligibility records, but they are all inactive. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **A** – An indicator of A means the provider is an active Medicaid provider and there are no MCO program eligibility records, active or inactive. If

you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.

- **I** – An indicator of I means the provider is an inactive Medicaid provider and there are no MCO program eligibility records, active or inactive. If you find this provider is a match, a PR1 request records would need to be submitted to activate program eligibility for you.
  Note: This would only apply to the MCOs that are not required to map to an active Medicaid provider.

If a match **is found** on the PRVLST file, the MCO updates the mandatory fields on the PR1 record and marks the record change indicator as 'A' to add their MCO eligibility to the specified KMAP provider. Please keep in mind the KMAP ID/SL **must** be included in the request. Refer to the PR1 Request File layout in Appendix A for the mandatory fields.

Note: If the MCO is mapping to an existing Medicaid Provider, it is essential to make sure all of the information matches for the MCO. For instance, on existing Medicaid providers the MCOs can not add a new specialty to the Medicaid provider. If the specialty for the MCO does not match to the existing Medicaid provider then the next process should be followed for if a match is not found.

If a match **is not found** on the PRVLST file, the MCO marks the record change indicator as 'A' and fills out all of the mandatory fields as indicated in the PR1 Request File layout in Appendix A. Please keep in mind when performing this task a KMAP ID/SL would **not** included in the request. This process will create a new KMAP ID/SL. This occurs when a provider in the MCO network is **not** found in the PRVLST file, meaning the MCO provider is not a KMAP provider.

The MCO may send updates to any of the PR1 fields; however, only the following fields are updated in the MMIS:

- Record Type
- Record Change Indicator
- MCO Medicaid Number
- MCO Service Location
- Provider Start Date
- Provider End Date
- PAR/Non-PAR

Activating A Provider No Longer Active:

If the MCO is needing to activate a provider no longer active in their network in order to submit historical claims for the provider to the MMIS the following steps must be followed in order to be successful.

- Send in "**Add**" records with an open "**End Date**" of 2299/12/31. When you receive the response file, you'll see the KMAP ID's for all the processed records.
  Note: If the end-date is equal to or prior to the processing date of the PR1 request file then it is considered a delete record. The provider record will be updated with program eligibility, however; a response will not be returned to the MCO.

- After you've received the KMAP ID's, send in "**Delete**" records with the actual "**end date**" that you want the provider to be active for.

For example, Provider "A" has been activated with an open ended date of 2299/12/31 but the Provider's actual program end date is 2010/10/01. In order to change the end date from 2299/12/31 to 2010/10/01, a "Delete" record needs to be sent in with an end date of "2010/10/01".

This will ensure that the encounters will process correctly for the dates of service the Provider is active for.

Note: Only those providers who were added to the MCO network since the last PR1 request to the MMIS should be marked as an 'add' record. The PR1 job should not be setup on an automatic scheduler on the MCO network.

Changing Program Eligibility Effective Date:

If the MCO needs to change their program eligibility effective date the following steps must be followed in order to be successful.

- Send in a "**Delete**" record with the corresponding **KMAP ID/SL** that needs to be updated. . If the record was created with the wrong effective date, the delete record should have an end date the same as the effective date.

- After the Delete request has been processed, send in "**Add**" records with the **KMAP ID/SL** and include the new program eligibility effective date.

Note: The KMAP ID/SL on both the Delete and the Add requests is required when making changes to the program eligibility effective date. Delete records will be dropped to the error report and the requested record will not be end dated if the KMAP ID/SL is not submitted.

Deleting providers:

When a program code is activated for a provider in error, mapped to the wrong provider, etc., the end date for the program eligibility needs to be the same as what the effective date is. When the program code has the same effective and end dates, this indicates the provider record is not valid.

If any of the providers are dropped from the MCO network, a 'delete' record should be created for the provider with the *Provider End Date* field populated. The MMIS will not delete the provider from the system, but update their *End Date* field to indicate that the provider is no longer active in the MCO network.

Note: Delete records do not generate a response record, so you will not see it on the provider response file. If the request record does not error off and report on the provider error file, the delete request was successful.

Once the MCO has completed the add and delete processes outlined above and have a finalized PR1 file, the MCO then sends this file back to KMAP by copying the file to a predefined folder on the MCOs FTP server. The KMAP EDI jobs, which consist of 5 jobs per submitter, pick up the files from that folder every 15 minutes and transfers the file(s) to the MMIS servers for processing. KMAP processes the PR1 request file from the MCOs once every week on Monday night at 7 p.m. and generates response and error files.

The PR1 Request file name and predefined folder name is illustrated below:

PR1 Request File Naming Convention	Folder Name
HW<19 or 21>_<MCO Medicaid Number>_PR1_<YYMMDDhhmmss>.dat PR1 indicates PR1 request file *(i.e. HW21_299999999A_PR1_070608190000.dat)*	Provider_Request

PR1 Response File (PRRP)

KMAP generates the PRRP file after the PR1 Request file has been processed. The PRRP file contains the KMAP ID/SL that has been assigned to the newly added Medicaid Providers. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRRP file is located in Appendix A.

The PRRP file name and predefined folder name is illustrated below:

PR1 Response File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRRP.<YYMMDDhhmmss>.dat PRRP indicates PR1 response file *(i.e. F.390663.299999999A.PRRP.070226210420.dat)*	Provider_Response

PR1 Error File (PRER)

KMAP generates the PRER file after the PR1 Request file has been processed. The PRER file returns information to the MCOs regarding PR1 records that failed the PR1 Request process. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRER file is located in Appendix A.

The PRER file name and predefined folder name is illustrated below:

PR1 Provider Error File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRER.<YYMMDDhhmmss>.dat PRER indicates PR1 provider error file *(i.e. F.390663.299999999A.PRER.070226210420)*	Provider_Error

Encounter Data Submission (837 Files)

Overview

MCO's must submit encounter data to KMAP using HIPAA X12 formatted 837 files for Institutional and Professional services, as well as NCPDP formatted files for pharmacy encounters. Please refer to the following HIPAA Companion Guides, located on the KMAP public website, for formatting questions:

- 837 Institutional Health Care Claim and Encounter Transactions
- 837 Professional Health Care Claim and Encounter Transactions
- NCPDP Transactions

837 File Creation

Production 837 and NCPDP files are limited to a HIPAA standard maximum of 25,000 claims total per file. There are no restrictions on the number of files an MCO can submit per day. All files will be stored in a queue at Hewlett-Packard (HP). As those files are processed, HP sends an email at approximately 7 a.m. and again around 7 p.m. to the loc-ksxix-mco-contact@external.groups.hp.com distribution list titled 'KSXIX - Encounter claims' with a listing of all the files that are **still waiting** to be processed.

Note: Along with the 837 or NCPDP files, KMAP requires a corresponding KM1 file be submitted before any processing of the 837 or NCPCP files will occur. The order of receipt does not matter on the 837 and KM1 files. The KM1 file process is described in Section 4: KMAP ID/SL Match File (KM1).

837 Billing Provider Specifics

For KMAP purposes, the Billing Provider is always the Pay-To Provider, so Loop 2010AB (Pay-To Provider Loop) should not be sent. When the Pay-To-Provider is different than the Billing Provider, HP will overlay the Pay-To-Provider with the Billing Provider information.

Note: With the implementation of the ANSI X12 5010 version of the 837 transactions on January 1, 2012, the definition of the Pay-To Provider fields are changing. The Pay-To Provider data will no longer be used when performing an NPI crosswalk for the Billing Provider.

The Billing Provider Loop 2010AA is preceded by Loop 2000A, the taxonomy code that will be associated with the Billing Provider Loop that follows. Taxonomy can be submitted in either the Loop 2000A or Loop 2310B, but KMAP prefers it to be submitted in Loop 2000A.

837 Test Files

MCOs are required to submit test files when first establishing a new MCO program, implementing new systems, or when there are MMIS directed format changes.

Since each MCO is different, when setting up test files for the very first time, the MCO needs to coordinate with HP to setup their test folder. The MCO will use their specific test folder for all testing with HP. Test files that are placed in the MCO‘s test folder will get picked up for our test region.

When submitting test files the MCOs need to notify HP by email with the Test file name, size and purpose for testing at loc-ksxix-mcoliaison@external.groups.hp.com.

Test files should be no larger than 25 claims. This is due to the tasks HP needs to complete prior to test files being processed in the MMIS. These tasks include the beneficiary and provider baseline process from the test files; this is a time consuming process if there are a high number of beneficiaries and providers to baseline. HP asks if the MCO’s test file fails the compliance test to not build new files with new beneficiaries and new providers. Please use the same beneficiaries and providers from the previous test file. This will expedite testing since HP will not have to baseline new beneficiaries and new providers.

If there is a need to test a larger sample of data, larger than 25 claims, please contact HP loc-ksxix-mcoliaison@external.groups.hp.com.

Compliance Testing

When testing compliance of an 837 file, an indicator of “T” for test must be used in ISA-15. Test files with a “T” in ISA-15 will pass through HP’s HIPAA translator to verify it

passes, and then be ignored. The file does not pass to the MMIS claims engine, no file or transaction processing occurs, and no automated notifications are sent. If the MCO wants to receive the 997 they must send a request to the MCOLiaison distribution list.

File Processing Testing

When testing file processing of an 837 file an indicator of "P" for production must be used in ISA-15. When test files are submitted with a "P" indicator, the response files are automatically generated and will prevent delays in getting the response files posted.

997 Functional Acknowledgement

The 997 transaction is an acknowledgement only to the sender that the submitted file has been accepted. Acceptance of the file does not mean that data is good. If you submitted an 837 file and it is missing, please make sure that you received a 997. If a 997 is not received within a day, please check for 837 compliance errors prior to sending an inquiry to HP.

Control Line Feed

When MCO's build their files it is important to remember that the MMIS requires the line feed to be a single byte, an Unix newline. If the file has a two byte Control Line Feed (CRLF) at the end of each data line, this will create an extra character. The unexpected extra character generates an error indicating an invalid header and/or trailer record. If the MCO is using a windows tool a two byte is returned.

Each end of text character should be immediately followed by a beginning of text character. This convention holds true for the entire file, including the header and trailer segments. MMIS is expecting no data (not even empty spaces) between each end of text and beginning of text markers. Following these guidelines will prevent extra spaces after the header and transaction segments in files.

HIPAA compliance problems support information

If HIPPA compliance problems occur, the MCO should contact the EDI Help Desk. All other processing concerns should be brought to the attention of the MCO Liaison. This includes questions about file processing or issues regarding the KMAP response files.

Contact information for support:

HP Technical Team after 5:00 PM	kspage.oncall@external.groups.hp.com
HP Cycle Technical Team after 5:00 PM	loc-ksxix.cycle.monitor@external.groups.hp.com
HP MCO Liaison Team	loc-ksxix-mcoliaison@external.groups.hp.com
HP EDI Help Desk	loc-ksxix-edikmap@external.groups.hp.com

KMAP ID/SL Match File (KM1)

Overview

The KM1 file is a companion file to the 837 used to designate the KMAP ID/SL associated with each NPI provider submitted in the 837. This file uses the MCO ICN to tie each record back to the 837 transaction. The KM1 is required for all encounter submissions.

The concept of the KM1 file was produced out of the need to create a one to one match between submitted provider information and the KMAP ID/SL used for processing encounters. The previous design of using the NPI crosswalk process resulted in an unacceptable number of defaulted rather than matched KMAP ID/SL codes. This new concept of using a KM1 file was proposed to KHPA and approved by KHPA in 2009.

Using this approach results in a direct one-to-one match of the KMAP ID/SL in all cases. This prevents improper processing of encounter data and greatly improves the quality of encounter data in MMIS. This solution also removes the need to manually manipulate provider records in MMIS to allow the NPI Crosswalk function to work correctly with the PR1 data in the many cases where the NPI, Provider Name, Taxonomy and Zip Code used by NPI crosswalk are identical for multiple KMAP ID/SL combinations.

KM1 File Creation

The information included in the KM1 file will allow HP to table the KMAP ID/SL information keyed to the MCO's specific internal ICN (Patient Account Number field in the 837 file). This key will tie to every provider ID included in the corresponding 837 file for that ICN. If a particular provider type is NOT used for that particular encounter, those fields in the match file record should be blank filled, as the KM1 file is a fixed record length file. The file layout for the KM1 file is located in Appendix A.

The KM1 record for header 0 corresponds to the providers submitted in loop 2310x. Edit 1056 (No match on either KM1 file or NPI) will post if a loop 2310x is submitted without a corresponding KMAP ID/SL on header 0 of the KM1 file. Likewise, KM1 detail records from 1 through N correspond to the providers submitted in loop 2420x. Edit 1057 (No match on either KM1 file or NPI) will post if the detail KMAP ID/SL are not submitted.

In order for the encounter process to work appropriately for MCOs required to submit KM1 files, all the provider information that is on the 837 must match accordingly to the KM1 file. For instance, if there is a Performing Provider NPI on the 837 file there has to be a KMAP ID/SL on the KM1 at the detail level.

If a rendering provider is submitted in loop 2310B (asserting that the rendering provider is the same for the entire claim except details containing loop 2420A), the KM1 file

should follow the same convention. The rendering provider KMAP ID/SL should only be submitted on the KM1 for details with a corresponding loop 2420A on the 837.

The naming convention for the KM1 File **must** follow the naming convention used for 837 file submission, with the exception of replacing the (837) in the file name with (KM1).

For example: If the created 837 submission file is named HW19**837**P20090605000001.dat, then the corresponding Match File would be named HW19**KM1**P20090605000001.dat. The only difference between the 2 file names is the 837 and the KM1 in the transaction section of the file name. See specific examples below for each file type.

File Type	Naming Convention
837 Professional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837P20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1P20071229190136)*

File Type	Naming Convention
837 Institutional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837I20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1I20071229190136)*

File Type	Naming Convention
NCPDP	HW <19 or 21> <trx> <time stamp> *(e.g. HW19NCP20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM120071229190136)*

Processing the KM1 file

HP checks the 837 file upon receipt to see if the file requires a KM1 file. If it does, HP then checks to see if the KM1 file is available. If the KM1 file is not available then the 837 file moves to the KM1-hold directory.

When HP receives KM1 files the information is automatically stored in a table and then checks to see if there is an 837 file in the KM1-hold directory. If there is a corresponding 837 file present it is then moved to the TODAY directory for processing. If there is not a corresponding 837 file present then no processing occurs until it is received. If there are any files awaiting a corresponding file in the hold directory for more than a day, HP will notify the MCO via email.

Prior to processing an encounter, the claims engine performs two verifications to validate the submitted provider information.

1. The first will be to make sure there is a match on the T_CLM_KM1 table with the submitted ICN, showing that the KM1 file has processed and that encounter's ICN is on the table.

2. The second will be a check of the NPI submitted in the 837 file for that ICN compared to the NPI number on file for the KMAP ID/SL submitted in the KM1 file. This check will apply to every provider type included in the file that has a submitted NPI in the 837 file.

If either of these two conditions fails to be met, the encounter will be denied and a response for that ICN will be included in the unsolicited 277 response file.

Denied professional and institutional encounters that were submitted incorrectly to MMIS will need to be corrected by following the void and replacement instructions, see Section 6: Void and Replacement Process.

KM1 Program Specific Instructions
MCOs

Pharmacy encounters are submitted in NCPDP 5.1 format, which does not have an ICN field. To compensate for this in the KM1 file, the MCO_ICN field will need to be created from the information submitted in the NCPDP file.

To accomplish this, the MCO_ICN field in the KM1 file is formatted as follows:

> Date Dispensed in YYJJJ Julian date format + 7 digit Prescription number (left zero filled) + Beneficiary ID minus the first three characters (usually 001). This will result in a 20 digit ICN that uniquely identifies the prescription.

For example, a prescription filled on February 1st, 2009 for Beneficiary ID 00101234567 with a prescription number of 134 would have an ICN of 09032000013401234567.

It is not uncommon to receive the same pharmacy claim numerous times on the same day since providers frequently resubmit until the claim goes through to a paid status. By using the combination of the Date Dispensed, Prescription Number (7 digits) and the Beneficiary ID (minus the first three characters) to create the unique MCO ICN, this is creating duplicate records in the KM1 file. If duplicate MCO ICN's are submitted on the same KM1 file, the first occurrence will be used to process all subsequent submissions of the same encounter. The possibility exists that if the subsequent submissions of the duplicated encounter had a change in the billing or prescribing provider, the encounter would not reflect this. If the MCO receives edit 1056 on their pharmacy encounters for this reason, they can void the encounter and resubmit with the correct information.

When ANSI X12 5010 format goes live on January 1, 2012, incorporating NCPDP D.0, this process may change because NCPDP D.0 has a new ICN field incorporated in it. The current solution was arrived at to leave the NCPDP 5.1 format unchanged and not require the inclusion of any new information.

Section 3: ***Encounter Claim Response Information***

Unsolicited 277 Response

The 277 Health Care Payer Unsolicited Claims Status (277) transaction provides claim status information for processed encounters. The generation of 277's occurs twice daily, approximately 7:00 a.m. and 7:00 p.m.. Please refer to the following Companion Guide, located on the KMAP public website, for formatting questions:

- 277 Health Care Payer Unsolicited Claims Status

MCO responsibility for 277 receipts

Once the 277 is received the following should occur:

- Review the Claim Status Category Code for each response. These status codes will appear at both the header and detail level.

Claim Status Category Code	**MMIS Claim Status**
F2	Deny
F1	Pay and List
F1	Pay

- Review the encounters returned with an F2 status code to determine the reason for the denial and to see if the encounter should be re-processed. Use the HIPAA Claim Status Codes, along with the current Edit/Audit Listing, to determine which submissions should be resubmitted for processing.

  Example:
  STC*F2:20*101025*NA*53.44****** ~
  REF*1K*7010298000314~
  DTP*472*RD8*20100608-20100608
  SVC*HC:A0100*53.44*0****2~
  STC*F2:53**NA*53.44******F2:585*F2:20*5001,4021~

  277 Example:

STC*F2:20*101025*NA*53.44	Header information: STC is the Claim Level Status Information F2, 20 is the claim status category and the claim status code respectively 101025 is the processing date 53.44 is the claim billed amount

REF*1K*7010298000314	7010298000314 is the MMIS ICN assigned to the encounter
DTP*472*RD8*20100608-20100608	Header information: 20100608-20100608 Claim dates of service
SVC*HC:A0100*53.44*0****2	Detail information: SVC is the Service Line Information A0100 is the detail procedure code 53.44 is the detail billed amount 0 is the amount paid for that detail 2 is the units of service billed on the detail
STC*F2:53**NA*53.44******F2:585*F2:20*5001,4021	STC here is the Service Line Status Information 53, 585 –Claim Status codes 5001, 4021 are the KMAP error codes

Note: It is possible to see responses with both F1 at the header indicating a paid claim, however, receiving an F2 at the detail level indicating a denied detail. The F2 detail line must be reviewed to determine the reason for the denial and to see if the encounter should be re-processed.

When encounter files are received and processed, and returned in a denied status, this should not be considered a 'rejection'. The encounter data has been accepted into the MMIS, processed and is available for analysis. Encounter files that fail the HIPAA Compliance check are considered rejects. When calculating acceptance rates the only true rejections would be reported on the 997's.

It is possible for a claim to reach a point in processing where the claims engine would not have the needed information to properly adjudicate (i.e. invalid provider or beneficiary information). When this happens, the information returned on the 277 could be from the header level of the claim only, and not the detail level. Claims will be processed to the fullest extent allowed by the submitted information. If the claim was denied at the header then the 277 will only report the header level information, no detailed information will be returned.

There could also be informational codes on encounter claims. Informational codes are generated throughout the processing of the encounter, and even if it results in a "paid" status at both the header and detail level, the informational codes should be reviewed for

data quality and content issues. There is no hard fast rule for what should or should not be investigated.

There is a spreadsheet that is shared with the MCO's that contains a list of edits and audits that could be returned on a 277. The spreadsheet is titled MCO Edit/Audit Listing ccyy (v.#). This list of edits and audits are ones the MCO's should always monitor to determine which submissions should be voided and resubmitted for processing.

Claims Status Code can be returned on a 277 which do NOT fall on the MCO Edit/Audit list, but should elicit a change/response from the MCO. For instance, if you should suddenly see a large volume of responses with 'invalid diagnosis code' you will need to see if a change occurred in your system, or contact HP at loc-ksxix-mcoliaison@external.groups.hp.com to verify if there was a change in our processing, that would have caused that code to suddenly return for so many encounters.

MCO responsibility for missing 277's

When an MCO submits an encounter data file, they may not receive a 277 transaction for all the data within that file at the same time. The 277 transaction is generated as HP processes encounters in the processing queue. They may not all be processed at the same time, this is due to the HP fee for service claims that get processed prior to encounter claims. It is very important that when HP sends out the 'KSXIX - Encounter claims' processing queue emails, each MCO needs to check to ensure the claim count has zeroed out before anymore data is submitted or prior to contacting HP regarding missing 277 transactions.

NCPDP Response

The NCPDP Response transaction provides claim status information for processed encounters. The generation of the NCPDP Response occurs once per submitted file and is created once the file has completed. Please refer to the following Companion Guide, located on the KMAP public website, for file specifics:

- KMAP NCPDP Companion Guide

MCO responsibility for NCPDP receipts

HP created a new spreadsheet for the NCPDP Reject Codes. This is a listing of every edit/audit in MMIS that has an NCPDP reject code assigned, regardless of the edit/audit disposition (pay, pay and list or deny). If there is an edit/audit in MMIS that does not have a reject code assigned, it will not be on this list. The formatting of this spreadsheet is similar to the Edit/Audit Listing and is titled NCPDP Reject Codes v#.##.

When the MCO receives the NCPDP responses, it is important to utilize this spreadsheet to determine what edits/audits posted on the encounters. If an NCPDP reject code is tied to an edit/audit in MMIS, the reject code is returned on the response file, not the EOB

code. However; if there is not a reject code tied to an edit/audit, the EOB code is returned. Reject codes will also be returned on the response file when the disposition for the edit/audit is set to pay. The following is an example of a claim in MMIS and the reject codes on the response file:

A pharmacy claim posted two edits;

- 1001 – Billing Provider Not Eligible For DOS
- 0556 – Claim Past 24 Month Filing

Both of these edits have reject codes in MMIS and both were on the response file:

- Reject code 40 is assigned to edit 1001
- Reject code 81 is assigned to edit 0556

Edit 1001 is set to deny on encounters but edit 0556 is set to pay.

The MCO will need to look to see which edits/audits have the reject code(s) from the response file. Then will need to determine if those edits/audits are ones that need to be monitored and resubmitted.

Void and Replacement Process

Overview

Encounters cannot be adjusted, therefore they must be updated through the Void and Replacement process. A void request is submitted for processing whenever an MCO needs to update claim information previously submitted through encounter data. The MCO may submit a new encounter to replace the voided encounter **after** the void action has completed and the MCO has received the response file for that void.

Before a void is sent the MCO needs to ensure they have a mechanism in place to prevent a void transaction from being sent on a claim that has not been accepted in MMIS as an encounter, and to ensure the void transaction is for an encounter that the MCO had submitted.

The chart displays a general outline of the Void and Replacement process.

Action	**Response**
Submit Original	Encounters get a paid or denied status and returned on 277 (region 70 ICN).
Void	Voids get a denied status (adjustment x-ref to link original/void) and returned on 277 (region 77 ICN)
Replacement	Replacement encounters get a paid or denied status and returned on 277 (new region 70 ICN)

A void transaction can be submitted for an encounter that has been paid or denied by the MMIS; however, it may not be necessary to submit a void claim when data correction is necessary. The following situations should be considered to determine if an encounter should be resubmitted with corrected information or a void transaction and a new encounter should be sent:

- Original claim received a "paid" MMIS status – send void and replacement
- Original claim received a "denied" MMIS status – this is situational; therefore, you can send a void and replacement or submit a new encounter with the corrected data.
    - If the denial is due to something you can fix to receive a MMIS "paid" status (such as a KMAP provider ID or NPI), send an updated transaction.
    - If you are correcting data on an encounter that a MMIS can't pay (such as a non-covered procedure code), send void and replacement.

Submitting Voids

Voids are completed at the header level and all details are voided. The MCO should send a separate file for 837P, 837I, and NCPDP voids. Successful voids will appear on the 277 and NCPDP response files.

Voids do not require a corresponding KM1 'record', but they do require a KM1 'file' to process. For example, if a pharmacy batch contains only voids, a corresponding KM1 file needs to be submitted but does not have to contain any data records. A KM1 file is required for all file types, however; voids to not require a record within the KM1 file.

Professional and Institutional Void process

The MCO will submit a void claim for the original encounter claim. The void must have:

- Code claim frequency of 8 (CLM05-3 - 2300 loop - cde_clm_frequency on Claim "header" tables).
- REF segment with F8 qualifier and KMAP's region 70 Internal Control Number (ICN) in the REF01 & REF02 - 2300 loop assigned to the original encounter claim that needs to be voided.

The MMIS process:

- Claims engine will check all of the following for a match:
    - Original ICN
    - Beneficiary ID
    - First Date of Service
    - Claim Billed Amount
- Links the void claim to the original claim by creating an entry in a cross-reference table.
- Assigns the void claim region 77 ICN.

- Turns on the new MMIS "action indicator" in the adjustment x-ref table that indicates the type of operation as re-submit.

Voided claims are sent on the 277 file.

Pharmacy Void process

Voids for pharmacy encounters are submitted in an NCPDP B2 transaction. Required data elements for the B2 transaction are specified in the KMAP NCPDP Companion Guide. Please refer to the KMAP NCPDP Companion Guide at the KMAP public website or by using the link below.

- KMAP NCPDP Companion Guide

Voids will appear on the NCPDP response files.

Note: Pharmacy encounters that are in a denied status in the MMIS cannot be voided.

Unsuccessful voids

Unsuccessful voids are reported on the "Bad Encounter Claims Report" produced internally at HP, which are then forwarded by email to the specific MCO reporting on the report. This report will have the following information:

- ICN (MMIS ICN to be voided)
- Patient Account Number (MCO ICN)
- Error Code
- Error Description

Most generally the error code that is reported will be 837-E11, which means that the original claim (MMIS ICN) could not be found. This error will be generated if all of the matching criteria (Original ICN, Beneficiary ID, First Date of Service, Claim Billed Amount) is not met.

If a void request is sent for an encounter that has already been successfully voided, the 277 will show a new 70 region ICN, but will also have an error 550 (Manual Deny Of Adjustments) at the end of the STC*F2 segment. This is NOT a new claim; it is a denied claim showing that the void failed. No further action for this is required.

Submitting Replacements

After a void is accepted, the 'replacement' is just sending the corrected encounter as if the voided encounter no longer exists in MMIS. The correct way to submit a replacement claim is by having the Claim code frequency (CLM05-3) of '1' indicating an original claim and REF F8 should not be submitted.

Section 4: ***Eligibility Rosters***

Overview

Enrollment rosters provide a detailed listing of assignments for beneficiaries in Managed Care. These rosters are created on a daily and monthly basis. These files may be generated on paper or electronic media. The electronic format files are generated in the HIPAA 834 transaction format. For questions on the 834 format please refer to the following HIPAA Companion Guide located on the KMAP public website or by accessing the link below:

- 834 Benefits Enrollment and Maintenance

Daily Rosters

The rosters are generated daily. New and terminated Primary Medicaid Providers (PMP) Assignments are reported in the daily process as usual. However, for continuing assignments, the daily process only lists those who have had a change in capitation category or a change in demographics. This significantly reduces the duplication of roster records from day to day, which makes the reports clearer and simpler to read/process.

Monthly Rosters

The monthly rosters are generated for all Managed Care programs. Unlike the daily process, all continuing assignments are listed in the roster reports/files. New records are also provided as usual. Monthly rosters are generated through the month end process which is scheduled to run on the 6th working day from the end of the month, beginning at 1:00 AM. The following chart is a list of dates for this fiscal year on which month end is scheduled to run in MMIS. Since month end does not run every month on the same date, please check to make sure month end has run before inquiring on the monthly 834 files.

Month	KAECSES Monthly Processing dates by HP (1AM on the day given below)
July 2010	07/23/2010
Aug 2010	08/24/2010
Sep 2010	09/23/2010
Oct 2010	10/22/2010
Nov 2010	11/19/2010
Dec 2010	12/22/2010
Jan 2011	01/22/2011
Feb 2011	02/19/2011
Mar 2011	03/24/2011

Apr 2011	04/22/2011
May 2011	05/21/2011
Jun 2011	06/23/2011

If the date is past the KAECSES monthly processing date and the roster has not been received, the MCO's need to contact HP loc-ksxix-mcoliaison@external.groups.hp.com.

Section 5: ***Encounter Data Attestations***

Overview

CMS requires that MCOs have administrative and management arrangements or procedures to guard against fraud and abuse. Part of those procedures includes the attestation or certification statements required from Managed Care Organizations regarding the accuracy, completeness and truthfulness of the data that is submitted. Below is the link to the Code of Federal Regulations requirement regarding certifications.

Electronic Code of Federal Regulations, Title 42: Public Health, PART 438 – Managed Care.

KDHE-DHCF has created a distribution group for all MCOs to use when sending their attestation forms. The group only contains members who have a need to receive the attestation forms.

KHPA_MCO_Attestation_Forms@khpa.ks.gov

If your MCO has an obligation to send your attestation forms to someone outside of KDHE, please continue to add those persons.

MCO Submission Checklist

This checklist should be used for each file submission to ensure that files are created and submitted correctly. If problems are encountered, please review the checklist to ensure that all requirements were met in the submission of the file.

Use the links in the checklist below for guidance within this manual.

	File Creation and Naming Conventions
☐	Designate file as Test or Prod
☐	Is File Naming Convention correct?
☐	Do the KM1 and 837 file names match including the file extension?
☐	Ensure that the file is using Unix newline rather than CRLF (carriage return line feed)
	837 File
☐	Are valid NPIs populated on the 837?
☐	Ensure that the 837 file has no more than 25,000 claims.
	KM1 file
☐	Has a corresponding KM1 file been built? (Optional for NEMT)
☐	Does the KM1 include the Billing Provider KMAP ID/SL?
	Notifications
☐	If Production File, send notification to Loc-ksxix-MCOLiaison@external.groups.hp.com when file(s) are submitted
☐	Send Attestation email to KHPA_MCO_Attestation_Forms@khpa.ks.gov and other appropriate State contact on the date of file submission
☐	If test file for more than HIPAA compliance check, send notification to Loc-ksxix-MCOLiaison@external.groups.hp.com.
	Problem Resolution
☐	Send email notification to Loc-ksxix-MCOLiaison@external.groups.hp.com if files are sitting on the FTP server for more than 2 hours
☐	Who to contact

Building Files

When MCO's build their files it is important to remember that the MMIS requires the line feed to be a single byte, a Unix newline. If the file has a two byte CRLF at the end of each data line, this will create an extra character. The unexpected extra character generates an error indicating an invalid header and/or trailer record.

Each end of text character should be immediately followed by a beginning of text character. This convention holds true for the entire file, including the header and trailer segments. MMIS is expecting no data (not even empty spaces) between each end of text

and beginning of text markers. Following these guidelines will prevent extra spaces after the header and transaction segments in files.

It also depends on the tool that is used to generate files. For instance, in Unix a single byte is returned, but in any windows tool a two byte is returned.

POA Field Inclusion

In December 2007, CMS distributed a POA Fact Sheet that explains how to format the POA data for submission electronically. That PDF document is available at http://www.cms.gov/HospitalAcqCond/downloads/POAFactsheet.pdf.

The full list of exempt provider types is available on the CMS website at http://www.cms.gov/HospitalAcqCond/03_AffectedHospitals.asp#TopOfPage.

The full description for proper coding of POA information can be found on the CMS website at http://www.cms.hhs.gov/HospitalAcqCond/05_Coding.asp#TopOfPage.

The editing for POA in MMIS is done by claim type, however; the claim type is assigned based on the type of bill submitted. When an encounter claim is submitted, the type of bill determines what the claim type will be. When we edit for POA, we do not look for type of bill 111, 112, 113, etc., we look for claim type 'I", which identifies an inpatient claim.
On the 837 Institutional claims, the CLM05-1 (Facility Code Value) and CLM05-2 (Facility Code Qualifier) are used to assign the claim type.

The following are the type of bills and their definitions that define Inpatient claims (claim type " I ") in MMIS:

110	Hospital - Inpatient (including Medicare Part A) - Nonpayment/zero Claim
111	Hospital - Inpatient (including Medicare Part A) - Admit thru discharge claim
112	Hospital - Inpatient (including Medicare Part A) - Interim - First claim
113	Hospital - Inpatient (including Medicare Part A) - Interim -Continuing claim
114	Hospital - Inpatient (including Medicare Part A) - Last claim (thru date is discharge date)
117	Hospital - Inpatient (including Medicare Part A) - Replacement of Prior Claim
118	Hospital - Inpatient (including Medicare Part A) - Void / Cancel of Prior Claim
120	Hospital - Inpatient (including Medicare Part B only) - Nonpayment/zero Claim
121	Hospital - Inpatient (including Medicare Part B only - Admit thru discharge claim
122	Hospital - Inpatient (including Medicare Part B only) - Interim - First claim
123	Hospital - Inpatient (including Medicare Part B only) - Interim - Continuing claim
124	Hospital - Inpatient (including Medicare Part B only) - Last claim (thru date is discharge date)
127	Hospital - Inpatient (including Medicare Part B only) - Replacement of Prior

	Claim
128	Hospital - Inpatient (including Medicare Part B only) - Void / Cancel of Prior Claim

Rejected vs. Denied

When inquiring with HP on the status of encounters it is crucial to use the correct terminology. When encounter files are received and processed, and returned in a 277 response file in a denied status, this is called a 'denied' encounter and should **not** be considered a 'rejection'. The encounter data has been accepted into the MMIS, processed, and is available for analysis.

Encounter files that fail the HIPAA Complicance check are considered 'rejects'. When calculating acceptance rates the only true rejections would be reported on the 997's.

Supplemental Delivery Payments

On a monthly basis, the previous month's claims are used to determine which encounter claims have procedure codes that will cause a "one-time lump sum delivery" payment to be generated. The "one-time lump sum delivery" payment covers the additional costs incurred by the MCO for the delivery of a child.

Criteria for Generating Lump Sum Payments

Professional (837P)

a) Professional encounter claim (encounter amount > 0);
b) Claim status from MCO is in 'paid' status;
c) Claim must go through financial and should be in history (aim01) database;
d) Date final or paid date is between the last and current run date of the beneficiary monthly cycle;
e) Claim has one of the following procedure code: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, and Y9512;
f) Claim must be received from one of the HW19 medical MCOs;

Institutional (837I)

a) Institutional encounter claim (encounter amount > 0);
b) Claim status from MCO is in 'paid' status;
c) Claim must go through financial and should be in history (aim01) database;
d) Date final or paid date is between the last and current run date of the beneficiary monthly cycle;
e) For claims with a date of service prior to 10/01/2008, claim has a DRG code between '370' and '375' (inclusive);

f) For claims with a date of service on or after 10/01/2008, claim has one of the following DRG codes: 765, 766, 767, 768, 774, and 775;
g) Claim must be received from one of the HW19 medical MCOs;

Detailed Criteria

a) Beneficiary is female;
b) Beneficiary is over the age of 12;
c) Claim has not been adjusted;
d) Beneficiary has a non-historied assignment in the HW19M program as of the claim's From Date of Service;
e) Claim was billed within 13 months of the From Date of Service;
f) Payment has not already been made for the beneficiary for other delivery claim within 10 months of current claim's from Date of Service

TPL Files

TPL Proprietary File

The TPL Proprietary File is used to update the MCOs' systems for the beneficiaries that have other insurance. This file ensures all systems have the most accurate data in relation to beneficiaries other insurance policies. Currently, a TPL Proprietary file is sent monthly to the MCOs so they can update their systems with the same information that is in the MMIS. The file name is t_mc_tpl_ext.dat and is used as a companion to the 834 monthly roster transaction. The file layout can be found in Appendix A: File Layouts.

TPL Lead Spreadsheet

The MCOs are responsible for returning a TPL Lead Spreadsheet to HP on the first of each month with the information from their system. The distribution to send the spreadsheet to is Loc-ksxix-MCO-TPL@external.groups.hp.com. HP uses this information to update the MMIS with the most up to date information. The spreadsheet layout can be found in Appendix A: File Layouts.

How to send the spreadsheet

It is KDHE Protected Health Information (PHI) policy that when sending PHI related information by electronic means, to ensure that PHI is protected:

- All documents must be password protected
- The password for the document needs to be sent in a separate email.
- The password must consists of eight characters with four unique character types (UPPER CASE, lower case, numbers (1 2 3), and symbols (.,-))
- The email must be encrypted

PRVLST Initial and Weekly File

The Initial and Weekly PRVLST layouts are the same as the PR1 Request File layout, except that the detail records in the PRVLST provider file have four additional fields:

- Medicaid Indicator
- Active Indicator
- Latitude
- Longitude

All records (that is, header, details, and trailer records) are fixed length records.

Note: Some of the MCO specific fields such as the following may not be populated in a PRVLST file.

- MCO Medicaid Number
- MCO Service Location
- MCO Assigned Number
- Provider Start Date
- Provider End Date

Header Record

Data Element:	Description:	Comments:	Field Length:	Type:	Required:
Header Record ID	Header record indicator	Value "HD#"	3	C	Y
Header Record Number			5	C	
Header Control Care Code			8	C	
Header Control Sequence			3	C	
Header Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Header Submitter Number			7	C	

Data Element:	Description:	Comments:	Field Length:	Type:	Required:
Header Test/Production Indicator		Values: "T" = Test "P" = Production	1	C	Y
Header Submit Date		CCYYMMDD	8	C	Y
Header Submit Time		HHMMSS	6	C	
Header Version			6	C	
MCO Medicaid Number	9-digit Medicaid number for the MCO	Billing Provider	9	C	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y
FILLER	Spaces	Spaces	329	C	

Detail Record

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Record Type	Roster record type	Always populate with "PR1"	3	C		Y
Record Change Indicator	This field indicates if the record is for adding, changing or deleting the PR1 provider	Valid values: "A" = Add "D" = Delete	1	C		Y
MCO Medicaid Number	9-digit Medicaid number for the MCO		9	C	Y	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y	Y
Provider Medicaid Number	9-digit Medicaid number for the provider	If available	9	C	Y	
Provider Service Location	1 character service location for the provider	If available	1	C	Y	

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider NPI	National Provider Identifier number assigned by the government to the provider	If applicable/available	10	C		
Provider License Number	State license number for the provider	If applicable/available	11	C		
Provider SSN	Provider's 9 digit Social Security Number without the dashes		9	C		Y
Provider FEIN	Federal Employer ID Number for the provider		9	C		Y
MCO Assigned Number	Internal provider number assigned to a provider by the MCO (MCO's internal number)	If applicable/available	15	C		
Provider Type	2-digit Kansas Medical Assistance Program (KMAP) provider type code	See valid provider type, specialty and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	2	C		Y
Provider Specialty	3-digit Kansas Medical Assistance Program (KMAP) provider specialty code	See valid provider type, specialty and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	3	C		Y
Provider Taxonomy	10 character provider taxonomy code	See valid provider type, specialty and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	10	C		

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Primary Language	Primary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Secondary Language	Any secondary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Hospital Admit Privileges	Medicaid-specific provider number (4 occurrences of X(12) characters each)		48	C	Y	
Provider Name Indicator	Type of name	"B" = Business "P" = Personal	1	C		Y
Provider Name	Name of provider	Personal – last name X(25), first name X(13), middle name X(12), title X(5) filler X(35) Business – business name X(50) filler X(40)	90	C		Y
Street Address 1	Provider's street address	Numeric street address, direction, name of street and suite number	32	C		Y
Street Address 2	2nd line of provider's street address		20	C		
City	Provider's city		18	C		Y
State	2 character state abbreviation	e.g. KS, MO	2	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
ZIP Code	Provider's ZIP code + 4	**ZIP Code +4:** All 9 characters must have numeric values – if not numeric it will be rejected. **Zip code (first 5 characters):** Required. Must be present and numeric – if 5 numeric values are not present, it will be rejected. **+4 field (last 4 characters):** Not required. If present it must be numeric – if not numeric it will be rejected. 1. If present the characters must = 4 (values greater than or = to 1 but less than 4 should be rejected.) 2. If all 4 characters are = 9 (9999) – drop the +4 3. If all 4 characters are = 0 (0000) – drop the +4	9	C		Y
Provider UPIN	Universal Provider Identification Number	If available	12	C		
Phone Number	Provider's office phone number		10	C		
Provider Start Date	Effective date provider contracted with the MCO	CCYYMMDD e.g. 20070101	8	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider End Date	Termination date of provider's contract with the MCO	CCYYMMDD Use 22991231 as an open end date	8	C		Y
County Code	County code associated with this location of the provider's practice	Use the 2 character county code from County Code Table in *PR1 Companion Guide*	2	C		Y
PAR/Non-PAR	Used to indicate whether the provider is a participating (PAR) or a non-participating (Non-PAR) provider	1 -indicates PAR 2 -indicates Non-PAR	1	C		Y
Medicaid Indicator	This indicates if the provider ID has Medicaid program eligibilities	'M' – Medicaid 'N' – Non-Medicaid	1	C	Y	
Active Indicator	Used to indicate the Active/inactive status and relationship to the MCO	M = Active for this MCO C = Active for at least one MCO, but not for this MCO O = Inactive Provider for at least one MCO, but no Active MCO Provider ID A = Active KMAP ID, but no Active or Inactive MCO Provider ID I = Inactive KMAP ID, but no Active or Inactive MCO Provider ID	1	C	Y	

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Latitude	This is the latitude of the provider address		15	C		
Longitude	This is the longitude of the provider address		15	C		
Provider Enrollment Indicator	This indicates whether the provider is enrolled as an individual or as a group	I=Individual G=Group	1	C		
FILLER	Spaces	Spaces	19	C		

Trailer Record

Data Element	Description	Comments:	Field Length:	Type:	Required:
Trailer Record ID	Trailer record indicator	Value "TR#"	3	C	Y
Trailer Record Number		Value "#####"	5	C	
Trailer Control Card Code		Values "PR"	8	C	
Trailer Control Card Sequence			3	C	
Trailer Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Trailer Submitter Number			7	C	
Trailer Test/Production Indicator		Values: "T" = Test "P" = Production	1	C	Y
Trailer Record Count	Total number of detail records in the PR1 file, i.e. the number of records in the file excluding the header and the trailer.		7	C	Y
Trailer Total Changes		COBOL PIC 9(7)V99	9	C	
FILLER	Spaces	Spaces	343	C	

PR1 Request File Layout

All records (i.e. header, details, and trailer records) are fixed length records. If any of the optional fields do not have data, spaces are to be inserted into the field to ensure that all records are of equal length. For example, if the *Street Address 2* field (20 characters) is not populated, insert 20 spaces into the field.

The header record is the first record of a PR1 Request File followed by multiple detail records and one trailer record as the last record. The field layout for all three record types in the PR1 Request Files is shown below.

Header Record

Data Element:	Description:	Comments:	Field Length:	Type:	Required:
Header Record ID	Header record indicator	Value "HD#"	3	C	Y
Header Record Number			5	C	
Header Control Care Code			8	C	
Header Control Sequence			3	C	
Header Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Header Submitter Number			7	C	
Header Test/Production Indicator		Values: "T" = Test "P" = Production	1	C	Y
Header Submit Date		CCYYMMDD	8	C	Y
Header Submit Time		HHMMSS	6	C	
Header Version			6	C	
MCO Medicaid Number	9-digit Medicaid number for the MCO	Billing Provider	9	C	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y
FILLER	Spaces	Spaces	329	C	

Detail Record

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Record Type	Roster record type	Always populate with "PR1"	3	C		Y
Record Change Indicator	This field indicates if the record is for adding, changing or deleting the PR1 provider	Valid values: "A" = Add "D" = Delete	1	C		Y
MCO Medicaid Number	9-digit Medicaid number for the MCO		9	C	Y	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y	Y
Provider Medicaid Number	9-digit Medicaid number for the provider	If available	9	C	Y	
Provider Service Location	1 character service location	If available	1	C	Y	
Provider NPI	National Provider Identifier (NPI) number assigned by the government to the provider	If applicable/available	10	C		
Provider License Number	State license number for the provider	If applicable/available	11	C		
Provider's SSN	Provider's 9 digit SSN without the dashes		9	C		Y
Provider FEIN Number	Federal Employer ID Number for the provider		9	C		Y
MCO Assigned Number	Internal provider number assigned to a provider by the MCO (MCO's internal number)		15	C		Y
Provider Type	Kansas Medical Assistance Program (KMAP) provider type code	See valid provider type, specialty, and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	2	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider Specialty	Kansas Medical Assistance Program (KMAP) provider specialty code	See valid provider type, specialty, and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	3	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider Taxonomy	10 character provider taxonomy code	See valid provider type, specialty, and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	10	C		
Primary Language	Primary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Secondary Language	Any secondary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Hospital Admit Privileges	Medicaid-specific provider number (4 occurrences of X(12) characters each)		48	C	Y	
Provider Name Indicator	Type of name	"B" = Business "P" = Personal	1	C		Y
Provider Name	Name of provider	Personal – last name X(25) first name X(13) middle name X(12) title X(5)	90	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
		filler X(35) Business – business name X(50) filler X(40)				
Street Address 1	Provider's street address	Numeric street address, direction, name of street and suite number	32	C		Y
Street Address 2	2nd line of provider's street address		20	C		
City	Provider's city		18	C		Y
State	2 character state abbreviation	e.g. KS, MO	2	C		Y
ZIP Code	Provider's ZIP code + 4	**ZIP Code +4:** All 9 characters must have numeric values – if not numeric it will be rejected. **Zip code (first 5 characters):** Required. Must be present and numeric – if 5 numeric values are not present, it will be rejected. **+4 field (last 4 characters):** Not required. If present it must be numeric – if not numeric it will be rejected. 1. If present the characters must = 4 (values greater than or = to 1 but less than 4 should be rejected.) 2. If all 4 characters are = 9 (9999) – drop the +4 3. If all 4 characters	9	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
		are = 0 (0000) – drop the +4				
Provider UPIN	Universal Provider Identification Number	If available	12	C		
Phone Number	Provider's office phone number		10	C		
Provider Start Date	Effective date provider contracted with the MCO	CCYYMMDD e.g. 20070101	8	C		Y
Provider End Date	Termination date of provider's contract with the MCO	CCYYMMDD Use 22991231 as an open end date	8	C		Y
County Code	County code associated with this location of the provider's practice	Use the 2 character county code from County Code Table in *PR1 Companion Guide*	2	C		Y
PAR/Non-PAR	Used to indicate whether the provider is a participating (PAR) or a non-participating (Non-PAR) provider.	1 = indicates PAR 2 = indicates Non-PAR	1	C		Y
FILLER	Spaces	Spaces	52	C		

Trailer Record

Data Element	Description	Comments:	Field Length:	Type:	Required:
Trailer Record ID	Trailer record indicator	Value "TR#"	3	C	Y
Trailer Record Number		Value "#####"	5	C	
Trailer Control Card Code		Values "PR"	8	C	
Trailer Control Card Sequence			3	C	
Trailer Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Trailer Submitter Number			7	C	
Trailer Test/Production Indicator		Values:	1	C	Y

Data Element	Description	Comments:	Field Length:	Type:	Required:
		"T" = Test "P" = Production			
Trailer Record Count	Total number of detail records in the PR1 file, i.e. the number of records in the file excluding the header and the trailer.		7	C	Y
Trailer Total Changes		COBOL PIC 9(7)V99	9	C	
FILLER	Spaces	Spaces	343	C	

PR1 Response File Layout

Data Element:	Description:	Field Length:	Type:
MCO Medicaid Provider Number	9-digit Medicaid number for the MCO	9	N
MCO Provider Service Location	1 character service location code for the MCO	1	C
Medicaid Provider Number	9-digit Medicaid number for the provider	9	N
Medicaid Provider Service Location	1 character service location code for the provider	1	C
MCO Assigned Number	Internal provider number assigned to a provider by the MCO.	15	C
Provider NPI	National Provider Identifier number assigned by the government to the provider	10	N
Provider Taxonomy	This is the 10 character provider taxonomy code	10	C
Address Separator character	This is the one character separator (~) between previous fields and provider address fields	1	C
Street Address 1	Provider's street address	30	C
Street Address 2	2nd line of provider's street address	20	C
City	Provider's city	15	C
State	2 character state abbreviation	2	C
Provider FEIN Number	Federal Employer ID Number or tax ID for the provider	9	N
FILLER	FILLER field reserved for future expansions, e.g. future additions of new fields to the response file.	120	C

PR1 Error File Layout

The Provider Error File contains the MCO's input record and the error code. The error file layout is the same as the PR1 detail record layout except the last field (i.e. 52 character FILLER field) contains an alphanumeric error code at the end, indicating why the record could not be processed. The error codes and corresponding error descriptions are listed below.

Error Code:	Error Short Description:	Detailed Description:
E700	Missing Rec Chg Ind	Missing Record Change Indicator should be A for ADD or D for Delete.
E705	Invalid Rec Chg Ind (A/D)	Invalid Record Change Indicator, should be A or D.
E710	Invalid Taxonomy Code	Invalid provider taxonomy code.
E715	Missing PAR Ind	Missing PAR/Non-PAR Indicator, should be 1 for PAR or 2 for Non-PAR.
E720	Invalid PAR Ind	Invalid PAR/Non-PAR Indicator, should be 1 or 2.
E725	Invalid Primary Lang Code	Invalid Primary Language Code.
E730	Invalid Secondary Lang Code	Invalid Secondary Language Code.
E735	Invalid Provider ID	Invalid Provider ID, i.e. the provider ID was not found in MMIS.
E740	Missing MCO Assigned Prov ID	No value was found in the MCO assigned Provider ID field.
E745	Missing or invalid provider ID	Missing or invalid provider ID.
E750	MCO-Provider relation not found	Provider is not part of the MCO network, cannot process a Delete record.
E755	Provider is inactive in MCO network	Provider is already inactive in the MCO network, cannot process a Delete record.
E760	Provider NPI is invalid	Provider's NPI is invalid.
E765	Provider NPI is not in MMIS	Provider's NPI is not in MMIS.
E770	Tax ID update not allowed for this provider	Tax ID update not allowed for this provider because it has multiple program eligibilities.
E775	Invalid or missing state abbreviation	Invalid or missing state abbreviation.
E780	Missing City Name	Missing City Name.
E785	Missing ZIP code	Missing ZIP code.
E786	Invalid ZIP code	ZIP Code +4: All 9 digits must have numeric values - if not numeric, it will be rejected. ZIP Code (first 5 digits): Required. Must be present and have 5 numeric values - if 5 numeric values are not present, it will be rejected. +4 (last 4 digits): Not required. If present it must be 4 numeric values - if not numeric it will be rejected. Values greater than or equal to 1 but less than 4 will be rejected. If all 4 values are equal to 0 (0000) or 9 (9999), it will be rejected.
E790	Provider NPI is not matching with MMIS	Provider's NPI in MMIS is different from the NPI that came via the PR1 record; therefore, the NPI update for this provider is not allowed due to its enrollment in other networks.
E795	Dental Providers are not allowed in PR1	Dental Providers are not allowed to be created through the PR1 process ***Note:*** This edit is no longer active effective 12/03/10
E800	Invalid MCO ID	MCO's provider ID is blank or invalid in MMIS.

Error Code:	Error Short Description:	Detailed Description:
E830	Invalid Effective Date	Date effective is invalid or blank.
E835	Invalid End Date	Date end is invalid or blank.
E925	Invalid Provider Name	Provider name is blank.
E930	Invalid Provider Name Ind	Provider name indicators can only be B =Business or P =Personal.
E935	Invalid SSN	Provider SSN is missing or invalid.
E940	Invalid FEIN	Provider FEIN is missing or invalid.
E945	Invalid License Num	Invalid provider license number.
E950	Invalid Address	First street address is blank.
E955	Invalid County Code	County code field is missing or invalid
E960	Invalid Type/Spec	Provider type, specialty code or the combination is invalid.
E965	Required info missing	Any of the required information is missing.
E970	Prov Service Loc exhausted	Provider service location has been maxed out and reached 'Z'.
E975	MCO ID in HDR does not match DTL	MCO provider on the header is different from the provider on each detail line.
E980	Unable to process PR1 record	PR1 record could not be processed due to some unknown reason, i.e. database failure.
E985	Future Effective Date	Date effective is greater than today's date.

PR1 NPI Addition E-mail Report Layout

If an MCO submits a provider number with an NPI for a provider for which HP does not have an NPI on file, the NPI will be added to the MMIS provider NPI table and an e-mail report will be sent to the Provider Enrollment unit (i.e. loc-ksxix-provider-enrollment@groups.hp.com). The PE unit will confirm the number with the provider and work with the MCO liaison if any communication between HP and the MCO is necessary. As the PR1 process is a weekly process this report is expected to be a weekly report.

Data Element:	Description:	Field Length:	Type:
MCO Medicaid Provider Number	9-digit Medicaid number for the MCO	9	N
MCO Provider Service Location	1 character service location code for the MCO	1	C
Medicaid Provider Number	9-digit Medicaid number for the provider	9	N
Medicaid Provider Service Location	1 character service location code for the provider	1	C
Provider NPI	National Provider Identifier (NPI) number assigned by the government to the provider	10	N
Provider Name	Name of provider	90	C

KM1Provider Match File

Column Name	Description	Type	Length	Required
MCO_SUBMITTER_ID	KMAP assigned Submitter ID for the submitting MCO.	ALPHA-NUMERIC	10	Required
MCO_ICN	MCO assigned key which uniquely identifies a claim in the system. For Pharmacy Claims submitted in NCPDP format, this field will be built as follows: Fill Date in YYJJJ Julian date format + 7 digit Prescription number (left zero filled) + Beneficiary ID minus the first three characters (usually 001). This will result in a 20 digit ICN that uniquely identifies the prescription.	ALPHA-NUMERIC	20	Required
CLAIM_DETAIL_ NUMBER	Line Number of the Service line in the 837 file (LX01). The line number for claim level Providers should be 0. Detail lines increment starting with 1. Any information at the Claim level or the Service line level on the 837 should have a corresponding match on the KM1 file.	NUMERIC	6	Required
BILLING_PROVIDER_KMAP_BASE	KMAP ID of billing provider submitted in the header loop of the claim. This information should correspond to the NPI submitted in the 2010AA loop on the 837.	NUMERIC	9	Required

Column Name	Description	Type	Length	Required
BILLING_PROVIDER _SL_CODE	Service Location Code of billing provider submitted in the header loop of the claim.	ALPHA	1	Required
PERF_PROVIDER_KMAP_BASE	KMAP ID of performing provider submitted in the header loop or detail loop of the claim. This information should correspond to the NPI submitted in the 2310B loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
PERF_PROVIDER _SL_CODE	Service Location Code of performing provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill
REFER1_PROVIDER_KMAP_BASE	KMAP ID of first referring provider submitted in the header loop or detail loop of the claim. On a Professional claim, this information should correspond to the NPI submitted in the 2310A loop on the 837. On an Institutional claim, this information should correspond to the NPI submitted in the 2310D loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
REFER1_PROVIDER _SL_CODE	Service Location Code of first referring provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill

Column Name	Description	Type	Length	Required
REFER2_PROVIDER_KMAP_BASE	KMAP ID of second referring provider submitted in the header loop or detail loop of the claim. On a Professional claim, this information should correspond to the NPI submitted in the 2310A loop on the 837. On an Institutional claim, this information should correspond to the NPI submitted in the 2310D loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
REFER2_PROVIDER _SL_CODE	Service Location Code of second referring provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill
ATTEND_PROVIDER_KMAP_BASE	KMAP ID of attending provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only. This information should correspond to the NPI submitted in the 2310A loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
ATTEND_PROVIDER _SL_CODE	Service Location Code of attending provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only.	ALPHA	1	Situational If not used, then blank fill

Column Name	Description	Type	Length	Required
OTHER1_PROVIDER_KMAP_BASE	KMAP ID of other1 (performing/rendering) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only. This information should correspond to the NPI in the 2310B loop on the 837	NUMERIC	9	Situational If not used, then blank fill
OTHER1_PROVIDER _SL_CODE	Service Location Code of other1 (performing/rendering) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only.	ALPHA	1	Situational If not used, then blank fill
OTHER2_PROVIDER_KMAP_BASE	KMAP ID of other2 (referring physician) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only. This information should correspond to the NPI in the 2310C loop on the 837	NUMERIC	9	Situational If not used, then blank fill
OTHER2_PROVIDER _SL_CODE	Service Location Code of other2 (referring physician) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only.	ALPHA	1	Situational If not used, then blank fill

Column Name	Description	Type	Length	Required
FACILITY_PROVIDER_KMAP_BASE	KMAP ID of facility provider submitted in the header loop or detail loop of the claim. On a Professional claim, this information should correspond to the NPI submitted in the 2330G loop on the 837. On an institutional claim, this information should correspond to the NPI submitted in the 2330H loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
FACILITY_PROVIDER _SL_CODE	Service Location Code of facility provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill
PRESCRIBER_PROVIDER_KMAP_ BASE	KMAP ID of prescribing provider submitted in the header loop or detail loop of the claim. This is applicable to pharmacy provider only. This information should correspond to the Prescriber segment of the claim on the NCPDP file.	NUMERIC	9	Situational If not used, then blank fill
PRESCRIBER_PROVIDER _SL_CODE	Service Location Code of prescribing provider submitted in the header loop or detail loop of the claim. This is applicable to pharmacy provider only.	ALPHA	1	Situational If not used, then blank fill

TPL Proprietary File Layout

Column Name	Type	Length
Beneficiary ID	CHAR	12
SSN	CHAR	9
Carrier Name	CHAR	45
Carrier Address 1	CHAR	30
Carrier Address 2	CHAR	30
Carrier City	CHAR	15
Carrier State	CHAR	2
Carrier Zip	CHAR	9
Policy Number	CHAR	16
Group Number	CHAR	16
Carrier Code	CHAR	7
Carrier Phone	CHAR	10
Policy Holder Name	CHAR	32
Policy code coverage	CHAR	1
Policy Start Date	CHAR	8
Policy End Date	CHAR	8
Relationship code	CHAR	1
Date Added	CHAR	8
Pay and Chase	CHAR	1

TPL Lead Spreadsheet Layout

Column	Column Name
A	BENEFICIARY NAME
B	BENE ID
C	SSN #
D	DOB
E	CARRIER NAME
F	CARRIER ADDRESS
G	CARRIER CITY
H	CARRIER STATE
I	CARRIER ZIP
J	POLICY #
K	GROUP #
L	PHONE #
M	POLICY HOLDER NAME IF OTHER THAN THE BENE
N	RELATIONSHIP
O	EFFECTIVE DATE
P	TERM DATE

PRVLST and PR1 Files

Initial and Weekly PRVLST File

Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRVLST.<YYMMDDhhmmss>.dat PRVLST indicates Provider Listing file *(i.e. F.390663.299999999A.PRVLST.070608190000.dat).*	Provider_FullListing

PR1 Request File

Naming Convention	Folder Name
HW<19 or 21>_<MCO Medicaid Number>_PR1_<YYMMDDhhmmss>.dat PR1 indicates PR1 request file *(i.e. HW21_299999999A_PR1_070608190000.dat)*	Provider_Request

PR1 Response File

Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRRP.<YYMMDDhhmmss>.dat PRRP indicates PR1 response file *(i.e. F.390663.299999999A.PRRP.070226210420.dat)*	Provider_Response

PR1 Error File

Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRER.<YYMMDDhhmmss>.dat PRER indicates PR1 provider error file *(i.e. F.390663.299999999A.PRER.070226210420)*	Provider_Error

837, NCPDP, and KM1 Files

The KMAP scripts will pick up any file in the target directory. However, the following naming conventions **must** be used:

File Type	Naming Convention
837 Professional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837P20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1P20071229190136)*

File Type	Naming Convention
837 Institutional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837I20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1I20071229190136)*

File Type	Naming Convention
NCPDP	HW <19 or 21> <trx> <time stamp> *(e.g. HW19NCP20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM120071229190136)*

- <trx> is the transaction type of the file – 837I, 837P, NCP, KM1
- <timestamp> is a timestamp to help make the filename unique (CCYYMMDDHHmmss or YYMMDDHHmmss)

Note: File extensions and suffixes may be used for additional identification, but if used the file extension (or suffix) **must be the same** for both the KM1 and 837 file.

Other KMAP Response Files

File Type	Naming Convention
Response files	<media>.<SAK>.<TPID>.<txn type>.<timestamp>.rsp.zip

- <media> is the transmission method - F for FTP, W for web upload, D for diskette
- <SAK> is either the SAK_DOWNLOAD assigned to the file or "0" to indicate that this file is not a direct response to an uploaded file (there is no SAK_UPLOAD associated with this file)
- <TPID> is the Trading Partner ID of the intended recipient of the file
- <txn type> is the transaction type of the file (such as 834, 277) - this value is used to route the file to the appropriate destination
- <timestamp> is a timestamp to help make the filename unique (CCYYMMDDHHmmss or YYMMDDHHmmss)
- rsp.zip - extensions to indicate that this is a zipped response file.

Examples:

File Type	Naming Convention
834 X12 - daily	out.2004945.29999999A.834.20071213121428.rsp.zip
834 X12 - monthly	out.2004945.29999999A.834.20071213121428m.rsp.zip
TPL Information	F.2004945.29999999A.MCOTPL.zip
997 X 12	F.3690.299999999A.997.rsp.zip
NCPDP	F.2004945.29999999A.NCP.txt.zip
Batch Submit Reports	batch_submit.3400.299999999A.rpt.zip
Unsolicited 277	out.2004945.29999999A.277PC.20071213121428.rsp.zip
820 X12	out.2004945.29999999A.820.20071213121428.rsp.zip

County Codes

County Number	County Abbreviation	County Name
001	AL	Allen
002	AN	Anderson
003	AT	Atchison
004	BA	Barber
005	BT	Barton
006	BB	Bourbon
007	BR	Brown
008	BU	Butler
009	CS	Chase
010	CQ	Chautauqua
011	CK	Cherokee
012	CN	Cheyenne
013	CA	Clark
014	CY	Clay
015	CD	Cloud
016	CF	Coffey
017	CM	Comanche
018	CL	Cowley
019	CR	Crawford
020	DC	Decatur
021	DK	Dickinson
022	DP	Doniphan
023	DG	Douglas
024	ED	Edwards
025	EK	Elk
026	EL	Ellis
027	EW	Ellsworth
028	FI	Finney
029	FO	Ford
030	FR	Franklin
031	GE	Geary
032	GO	Gove
033	GH	Graham
034	GT	Grant
035	GY	Gray

County Number	County Abbreviation	County Name
036	GL	Greeley
037	GW	Greenwood
038	HM	Hamilton
039	HP	Harper
040	HV	Harvey
041	HS	Haskell
042	HG	Hodgeman
043	JA	Jackson
044	JF	Jefferson
045	JW	Jewell
046	JO	Johnson
047	KE	Kearney
048	KM	Kingman
049	KW	Kiowa
050	LB	Labette
051	LE	Lane
052	LV	Leavenworth
053	LC	Lincoln
054	LN	Linn
055	LG	Logan
056	LY	Lyon
057	MN	Marion
058	MS	Marshall
059	MP	McPherson
060	ME	Meade
061	MI	Miami
062	MC	Mitchell
063	MG	Montgomery
064	MR	Morris
065	MT	Morton
066	NM	Nemaha
067	NO	Neosho
068	NS	Ness
069	NT	Norton
070	OS	Osage
071	OB	Osborne
072	OT	Ottawa
073	PN	Pawnee
074	PL	Phillips
075	PT	Pottawatomie
076	PR	Pratt
077	RA	Rawlins
078	RN	Reno

County Number	County Abbreviation	County Name
079	RP	Republic
080	RC	Rice
081	RL	Riley
082	RO	Rooks
083	RH	Rush
084	RS	Russell
085	SA	Saline
086	SC	Scott
087	SG	Sedgwick
088	SW	Seward
089	SN	Shawnee
090	SD	Sheridan
091	SH	Sherman
092	SM	Smith
093	SF	Stafford
094	ST	Stanton
095	SV	Stevens
096	SU	Sumner
097	TH	Thomas
098	TR	Trego
099	WB	Wabaunsee
100	WA	Wallace
101	WS	Washington
102	WH	Wichita
103	WL	Wilson
104	WO	Woodson
105	WY	Wyandotte
106	OO	Out-Of-State
107	CO	Colorado
108	MO	Missouri
109	NE	Nebraska
111	OK	Oklahoma
112	AR	Arkansas

Language Codes

Language Code	Language
AR	Arabic
BN	Bosnian
CA	Cantonese
CH	Chinese
CM	Cambodian
CZ	Czech
DU	Dutch
EN	English
FR	French
GE	German
GK	Greek
GU	Gujarathi
HM	Hmong
HN	Hindi
IT	Italian
JP	Japanese
KA	Kannada
KN	Korean
LA	LAO
MA	Mandarin
MK	Mon-Khmer
NN	None
OT	Other
PE	Persian
PL	Polish
PT	Portuguese
RU	Russian
SC	Serbo-Croatian
SM	Somali
SP	Spanish
SU	Sudanese
TA	Tamil
TG	Tagalog
TH	Thai
UN	Unknown
UR	Urdu
VN	Vietnamese

Provider Type Codes

Type Code	Type Description
01	Hospital
02	Ambulatory Surgical Center (ASC)
03	Custodial Care Facility
04	Rehabilitation Facility
05	Home Health Agency
06	Hospice
07	Capitation Provider
08	Clinic
09	Advance Practice Nurse
10	Mid-Level Practitioner
11	Mental Health Provider
12	Local Education Agency
13	Public Health Agency
14	Podiatrist
15	Chiropractor
16	Nurse
17	Therapist
18	Optometrist
19	Optician
20	Audiologist
21	Case Manager (Targeted)
22	Hearing Aid Dealer
23	Nutritionist
24	Pharmacy
25	DME/Medical Supply Dealer
26	Transportation Provider
27	Dentist
28	Laboratory
29	X-Ray Clinic
30	Renal Dialysis Center
31	Physician
36	Personal Care Services
38	Respite Care
41	Adult Day Care
42	Teaching Institution
43	Homemaker Services
44	Home Modifications
45	QMB
53	Head Start Facility
55	HCBS
56	Work
70	Data Access Entity

Provider Specialty Codes

Specialty Code	Specialty Description
010	Acute Care
011	Psychiatric
012	Rehabilitation
013	Residential Treatment Center
014	Critial Access
015	Children's Specialty
016	Emergency
017	Tuberculosis
018	State Institution
019	State Mental Hospital
020	Ambulatory Surgical Center (ASC)
030	Nursing Facility
031	ICF/MR Extra Care
032	Pediatric Nursing Facility
033	Residential Care Facility
034	ICF/MR Private
035	Skilled Nursing Facility
036	Respite Care - Facility Based
037	Assisted Living
040	Rehabilitation Facility
041	Head Injury Rehabilitation
042	Non-CMHC Partial Hospitalization
050	Home Health Agency
051	Specialized Home Nursing Services
053	Respite Care Home and Community Based Services
054	Waivered Case Management
059	Independent Living Counseling
060	Hospice
071	Managed Care Organization (MCO)
072	Family Preservation Contract
073	Adoption Contract
074	Foster Care Contract
075	PACE
076	Care Management
080	Federally Qualified Health Clinic (FQHC)
081	Rural Health Clinic (RHC)
082	Medical Clinic
083	Family Planning Clinic
084	Nurse Practitioner Clinic
085	EPSDT Clinic

Specialty Code	Specialty Description
086	Dental Clinic
087	Therapy Clinic
088	Pediatric Clinic
089	Tuberculosis Clinic
090	Pediatric Nurse Practitioner
091	Obstetric Nurse Practitioner
092	Family Nurse Practitioner
093	Nurse Practitioner (Other)
094	Certified Registered Nurse Anesthetist (CRNA)
095	Certified Nurse Midwife
096	Psychiatric Nurse Practitioner
100	Physician Assistant
101	Anesthesiology Assistant
108	Licensed Master.s Level Psychologist -LMLP **effective DOS 1/1/11
109	Licensed Clinical Psychotherapist -LCP **effective DOS 1/1/11
110	Outpatient Mental Health Clinic
111	Community Mental Health Center (CMHC)
112	Psychologist
113	Residential Alcohol/Drug Abuse Treatment Facility
114	Health Service Provider in Psychology(HSPP)
115	Licensed Mental Health Professional-LMHP
116	Licensed Clinical Mental Health Professional-LCMHP
117	Psychiatric Nurse
118	Mental Health - DMHSAS
119	Marriage and Family Counselor
120	Local Education Agency
122	Non-CMHC Affiliate
123	Children with Severe Emotional Disturbances
124	CMHC Partial Hospitalization
130	County Health Department
131	Public Health or Welfare Agency and Clinic
140	Podiatrist
150	Chiropractor
160	Registered Nurse(RN)
161	Licensed Practical Nurse(LPN)
162	Registered Nurse Clinical(RNC)
163	Skilled Nursing Agency
170	Physical Therapist
171	Occupational Therapist
172	Respiratory Therapist

Specialty Code	Specialty Description
173	Speech/Hearing Therapist
174	Occupational Therapy Assistant
175	Physical Therapy Assistant
176	Alcohol and Drug Rehabilitation
177	Behavioral Therapy
178	Cognitive Therapy
180	Optometrist
181	Maternity
182	Speech/Hearing Clinic
183	Early Intervention Services
184	Hospital Based Rural Health Clinic
185	Free Standing Rural Health Clinic
186	Family Service Coordination for ECI
190	Optician
191	Ocularist
200	Audiologist
220	Hearing Aid Dealer
230	Nutritionist
231	Assistive Technology
232	Behavior Management/PRTF
233	Community Developmental Disability Organization
236	Screening
237	Targeted Case Management
238	Non-CDDO Affiliate
240	Pharmacy
241	Institutional Pharmacy
242	Pharmacy Mail (Out of State)
250	DME/Medical Supply Dealer
252	Emergency Response - Installation
253	Emergency Response - Rental
254	Optical Supplier
255	Vaccine Administration
256	Van Lifts
257	Wheelchair Modifications
260	Ambulance
261	Air Ambulance
262	Bus
263	Taxi
264	Common Carrier (Ambulatory)
265	Common Carrier (Non-ambulatory)
266	Family Member
267	Driver
268	Medical Alert

Specialty Code	Specialty Description
270	Endodontist
271	General Dentistry Practitioner
272	Oral Surgeon
273	Orthodontist
274	Pediatric Dentist
275	Periodontist
276	Oral Pathologist
277	Prosthesis
280	Independent Lab
281	Mobile Lab
282	KDHE Lab Billing
283	Pathology Lab
290	Free Standing X-Ray Clinic
291	Mobile X-Ray Clinic
292	Mammography
293	Diagnostic X-Ray
300	Renal Dialysis Center
310	Allergist
311	Anesthesiologist
312	Cardiologist
313	Cardiovascular Surgeon
314	Dermatologist
315	Emergency Medicine Practitioner
316	Family Practitioner
317	Gastroenterologist
318	General Practitioner
319	General Surgeon
320	Geriatric Practitioner
321	Hand Surgeon
322	Internist
323	Neonatologist
324	Nephrologist
325	Neurological Surgeon
326	Neurologist
327	Nuclear Medicine Practitioner
328	Obstetrician/Gynecologist
329	Oncologist
330	Opthamologist
331	Orthopedic Surgeon
332	Otologist, Laryngologist, Rhinologist
333	Pathologist
334	Pediatric Surgeon
335	Maternal Fetal Medicine
336	Physical Medicine and Rehabilitation Practitioner

Specialty Code	Specialty Description
337	Plastic Surgeon
338	Proctologist
339	Psychiatrist
340	Pulmonary Disease Specialist
341	Radiologist
342	Thoracic Surgeon
343	Urologist
344	General Internist
345	General Pediatrician
346	Dispensing Physician
347	Radiation Therapist
348	Addiction Medicine
349	Exempt License Physician
350	Preventative Medicine
351	Indian Health Services
360	Personal Care - Individual
361	Personal Care - Agency
362	Family/Individual Supports
363	Personal Services - HI
364	Residential Supports
365	Supportive Home Care
366	Night Support - HI
367	Personal Services - PD
368	Sleep Cycle Support - MRDD
369	Supported Employment Services - MRDD
370	Personal Assistant Services - MRDD
380	Respite Care - Community Based
381	Respite Care - Home Based
410	Adult Day Care
430	Homemaker Services
440	Assistive Services
441	Assistive Technology Services
450	QMB
500	Assistive Services - PD
501	Attendant Care for Independent Living (ACIL)
502	Communication Devices
503	Assistive Services - HI
506	Independent Living Counselor
509	Medication Reminder
510	Attendant Care - Level I
511	Attendant Care - Level II
512	Respite Care - MRDD
513	Sleep Cycle Support
514	Wellness Monitoring - FE

Specialty Code	Specialty Description
515	Nursing Evaluation
516	Respite Care - FE
517	Wellness Monitoring - MRDD
518	Comprehensive Support Services - FE
520	Day Supports
521	Specialized Medical Care RN/MRDD
522	Assessment Service
523	Specialized Medical Care LPN/MRDD
526	Assistive Services
540	Transitional Living Skill
550	Autism Specialist
551	Intensive Individual Support - AU
552	Respite Care - AU
553	Parent Support - AU
554	Family Adjustment Counseling - AU
555	Case Management/Care Coordination/TA
556	Medical Respite/TA
557	Medical Service Technician/TA
558	Personal Service Attendant/TA
559	Home Modifications/TA
700	Eligibility Inquiry/Verification
999	Mixed Specialty for SURS

Provider Type, Specialty, and Taxonomy Codes

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
01	Hospital	010	Acute Care	282N00000X
01	Hospital	011	Psychiatric	283Q00000X
01	Hospital	012	Rehabilitation	283X00000X
01	Hospital	013	Residential Treatment Center	323P00000X
01	Hospital	014	Critial Access	282N00000X
01	Hospital	015	Children's Specialty	282NC2000X
01	Hospital	016	Emergency	282N00000X
01	Hospital	017	Tuberculosis	281P00000X
01	Hospital	018	State Institution	315P00000X
01	Hospital	019	State Mental Hospital	283Q00000X
01	Hospital	351	Indian Health Services	282N00000X
02	Ambulatory Surgical Center (ASC)	020	Ambulatory Surgical Center (ASC)	261QA1903X
03	Custodial Care Facility	011	Psychiatric	283Q00000X
03	Custodial Care Facility	030	Nursing Facility	313M00000X
03	Custodial Care Facility	031	ICF/MR Extra Care	315P00000X
03	Custodial Care Facility	032	Pediatric Nursing Facility	313M00000X
03	Custodial Care Facility	033	Residential Care Facility	314000000X
03	Custodial Care Facility	034	ICF/MR Private	315P00000X
03	Custodial Care Facility	035	Skilled Nursing Facility	314000000X
03	Custodial Care Facility	036	Respite Care - Facility Based	314000000X
03	Custodial Care Facility	037	Assisted Living	311Z00000X
03	Custodial Care Facility	410	Adult Day Care	311Z00000X
03	Custodial Care Facility	510	Attendant Care - Level I	311Z00000X
03	Custodial Care Facility	511	Attendant Care - Level II	311Z00000X
03	Custodial Care Facility	513	Sleep Cycle Support	311Z00000X
03	Custodial Care Facility	514	Wellness Monitoring - FE	311Z00000X
03	Custodial Care Facility	515	Nursing Evaluation	314000000X
03	Custodial	516	Respite Care - FE	311Z00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Care Facility			
04	Rehabilitation Facility	040	Rehabilitation Facility	261QR0400X
04	Rehabilitation Facility	041	Head Injury Rehabilitation	283X00000X
04	Rehabilitation Facility	042	Non-CMHC Partial Hospitalization	283Q00000X
05	Home Health Agency	050	Home Health Agency	251E00000X
05	Home Health Agency	051	Specialized Home Nursing Services	251E00000X
05	Home Health Agency	053	Respite Care Home and Community Based Services	251E00000X
05	Home Health Agency	054	Waivered Case Management	251E00000X
05	Home Health Agency	059	Independent Living Counseling	251E00000X
05	Home Health Agency	252	Emergency Response - Installation	251E00000X
05	Home Health Agency	253	Emergency Response - Rental	251E00000X
05	Home Health Agency	268	Medical Alert	251E00000X
05	Home Health Agency	363	Personal Services - HI	251E00000X
05	Home Health Agency	366	Night Support - HI	251E00000X
05	Home Health Agency	367	Personal Services - PD	251E00000X
05	Home Health Agency	501	Attendant Care for Independent Living (ACIL)	251E00000X
05	Home Health Agency	510	Attendant Care - Level I	251E00000X
05	Home Health Agency	511	Attendant Care - Level II	251E00000X
05	Home Health Agency	513	Sleep Cycle Support	251E00000X
05	Home Health Agency	514	Wellness Monitoring - FE	251E00000X
05	Home Health Agency	515	Nursing Evaluation	251E00000X
05	Home Health Agency	516	Respite Care - FE	251E00000X
05	Home Health Agency	517	Wellness Monitoring - MRDD	251E00000X
05	Home Health Agency	521	Specialized Medical Care RN/MRDD	163W00000X
05	Home Health	523	Specialized Medical Care	164W00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Agency		LPN/MRDD	
05	Home Health Agency	556	Medical Respite/TA	385H00000X
05	Home Health Agency	557	Medical Service Technician/TA	3747A0650X
06	Hospice	060	Hospice	315D00000X
07	Capitation Provider	071	Managed Care Organization (MCO)	302R00000X
07	Capitation Provider	072	Family Preservation Contract	251B00000X
07	Capitation Provider	073	Adoption Contract	251B00000X
07	Capitation Provider	074	Foster Care Contract	251B00000X
07	Capitation Provider	075	PACE	314000000X
07	Capitation Provider	076	Care Management	251B00000X
08	Clinic	080	Federally Qualified Health Clinic (FQHC)	261QF0400X
08	Clinic	081	Rural Health Clinic (RHC)	261QR1300X
08	Clinic	082	Medical Clinic	261QP2300X
08	Clinic	083	Family Planning Clinic	261QA0005X
08	Clinic	084	Nurse Practitioner Clinic	363L00000X
08	Clinic	085	EPSDT Clinic	261QP0904X
08	Clinic	086	Dental Clinic	261QD0000X
08	Clinic	087	Therapy Clinic	261QP2000X
08	Clinic	088	Pediatric Clinic	261QH0100X
08	Clinic	089	Tuberculosis Clinic	261QH0100X
08	Clinic	181	Maternity	261QB0400X
08	Clinic	182	Speech/Hearing Clinic	261QH0100X
08	Clinic	183	Early Intervention Services	251B00000X
08	Clinic	184	Hospital Based Rural Health Clinic	261QR1300X
08	Clinic	185	Free Standing Rural Health Clinic	261QR1300X
08	Clinic	186	Family Service Coordination for ECI	251B00000X
09	Advance Practice Nurse	090	Pediatric Nurse Practitioner	363LP0200X
09	Advance Practice Nurse	091	Obstetric Nurse Practitioner	363LX0001X
09	Advance Practice Nurse	092	Family Nurse Practitioner	363LF0000X
09	Advance Practice Nurse	093	Nurse Practitioner (Other)	363L00000X
09	Advance Practice Nurse	094	Certified Registered Nurse Anesthetist (CRNA)	367500000X
09	Advance	095	Certified Nurse Midwife	367A00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Practice Nurse			
09	Advance Practice Nurse	096	Psychiatric Nurse Practitioner	363LP0808X
10	Mid-Level Practitioner	100	Physician Assistant	363A00000X
10	Mid-Level Practitioner	101	Anesthesiology Assistant	367500000X
11	Mental Health Provider	108	Licensed Master.s Level Psychologist -LMLP ** effective 1-1-2011	103T00000X
11	Mental Health Provider	109	Licensed Clinical Psychotherapist – LCP ** effective 1-1-2011	103T00000X
11	Mental Health Provider	110	Outpatient Mental Health Clinic	261QM0801X
11	Mental Health Provider	111	Community Mental Health Center (CMHC)	261QM0801X
11	Mental Health Provider	112	Psychologist	103T00000X
11	Mental Health Provider	113	Residential Alcohol/Drug Abuse Treatment Facility	324500000X
11	Mental Health Provider	114	Health Service Provider in Psychology(HSPP)	103T00000X
11	Mental Health Provider	115	Licensed Mental Health Professional-LMHP	104100000X
11	Mental Health Provider	116	Licensed Clinical Mental Health Professional-LCMHP	1041C0700X
11	Mental Health Provider	117	Psychiatric Nurse	163WP0808X
11	Mental Health Provider	118	Mental Health - DMHSAS	261QM0801X
11	Mental Health Provider	119	Marriage and Family Counselor	106H00000X
11	Mental Health Provider	122	Non-CMHC Affiliate	261QM0801X
11	Mental Health Provider	123	Children with Severe Emotional Disturbances	261QM0801X
11	Mental Health Provider	124	CMHC Partial Hospitalization	261QM0801X
11	Mental Health Provider	176	Alcohol and Drug Rehabilitation	261QM0801X
11	Mental Health Provider	178	Cognitive Therapy	261QM0801X
11	Mental Health Provider	232	Behavior Management/PRTF	323P00000X
12	Local Education Agency	120	Local Education Agency	261QS1000X
13	Public Health	130	County Health Department	251K00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Agency			
13	Public Health Agency	131	Public Health or Welfare Agency and Clinic	251K00000X
13	Public Health Agency	181	Maternity	251K00000X
13	Public Health Agency	510	Attendant Care - Level I	251K00000X
13	Public Health Agency	511	Attendant Care - Level II	251K00000X
13	Public Health Agency	514	Wellness Monitoring - FE	251K00000X
13	Public Health Agency	515	Nursing Evaluation	251K00000X
14	Podiatrist	140	Podiatrist	213E00000X
15	Chiropractor	150	Chiropractor	111N00000X
16	Nurse	160	Registered Nurse(RN)	163W00000X
16	Nurse	161	Licensed Practical Nurse(LPN)	164W00000X
16	Nurse	162	Registered Nurse Clinical(RNC)	163W00000X
16	Nurse	163	Skilled Nursing Agency	251J00000X
16	Nurse	514	Wellness Monitoring - FE	163WG0000X
16	Nurse	515	Nursing Evaluation	163WG0000X
16	Nurse	517	Wellness Monitoring - MRDD	163WG0000X
17	Therapist	170	Physical Therapist	225100000X
17	Therapist	171	Occupational Therapist	225X00000X
17	Therapist	172	Respiratory Therapist	227800000X
17	Therapist	173	Speech/Hearing Therapist	235Z00000X
17	Therapist	174	Occupational Therapy Assistant	224Z00000X
17	Therapist	175	Physical Therapy Assistant	225200000X
17	Therapist	176	Alcohol and Drug Rehabilitation	103TR0400X
17	Therapist	177	Behavioral Therapy	103TR0400X
17	Therapist	178	Cognitive Therapy	103TR0400X
17	Therapist	540	Transitional Living Skill	225100000X
18	Optometrist	180	Optometrist	152W00000X
19	Optician	190	Optician	156FX1700X
19	Optician	191	Ocularist	156FX1700X
20	Audiologist	200	Audiologist	231H00000X
21	Case Manager (Targeted)	186	Family Service Coordination for ECI	251B00000X
21	Case Manager (Targeted)	231	Assistive Technology	251B00000X
21	Case Manager (Targeted)	232	Behavior Management/PRTF	251B00000X
21	Case Manager (Targeted)	233	Community Developmental Disability Organization	251B00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
21	Case Manager (Targeted)	237	Targeted Case Management	251B00000X
21	Case Manager (Targeted)	238	Non-CDDO Affiliate	251B00000X
21	Case Manager (Targeted)	520	Day Supports	251B00000X
22	Hearing Aid Dealer	220	Hearing Aid Dealer	332S00000X
23	Nutritionist	230	Nutritionist	133V00000X
24	Pharmacy	240	Pharmacy	333600000X
24	Pharmacy	241	Institutional Pharmacy	333600000X
24	Pharmacy	242	Pharmacy Mail (Out of State)	333600000X
24	Pharmacy	250	DME/Medical Supply Dealer	333600000X
24	Pharmacy	346	Dispensing Physician	330000000X
24	Pharmacy	351	Indian Health Services	332800000X
25	DME/Medical Supply Dealer	250	DME/Medical Supply Dealer	332B00000X
25	DME/Medical Supply Dealer	252	Emergency Response - Installation	332B00000X
25	DME/Medical Supply Dealer	253	Emergency Response - Rental	332B00000X
25	DME/Medical Supply Dealer	254	Optical Supplier	332H00000X
25	DME/Medical Supply Dealer	255	Vaccine Administration	332B00000X
25	DME/Medical Supply Dealer	256	Van Lifts	332BC3200X
25	DME/Medical Supply Dealer	257	Wheelchair Modifications	332BC3200X
25	DME/Medical Supply Dealer	268	Medical Alert	332B00000X
25	DME/Medical Supply Dealer	277	Prosthesis	335E00000X
25	DME/Medical Supply Dealer	440	Assistive Services	332B00000X
25	DME/Medical Supply Dealer	441	Assistive Technology Services	332B00000X
25	DME/Medical Supply Dealer	500	Assistive Services - PD	332BC3200X
25	DME/Medical Supply Dealer	503	Assistive Services - HI	332BC3200X
26	Transportation Provider	260	Ambulance	3416L0300X
26	Transportation Provider	261	Air Ambulance	3416A0800X
26	Transportation Provider	262	Bus	343900000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
26	Transportation Provider	263	Taxi	343900000X
26	Transportation Provider	264	Common Carrier (Ambulatory)	343900000X
26	Transportation Provider	265	Common Carrier (Non-ambulatory)	343900000X
26	Transportation Provider	266	Family Member	347C00000X
26	Transportation Provider	267	Driver	347C00000X
27	Dentist	270	Endodontist	1223E0200X
27	Dentist	271	General Dentistry Practitioner	122300000X
27	Dentist	272	Oral Surgeon	1223S0112X
27	Dentist	273	Orthodontist	1223X0400X
27	Dentist	274	Pediatric Dentist	1223P0221X
27	Dentist	275	Periodontist	1223P0221X
27	Dentist	276	Oral Pathologist	1223P0106X
27	Dentist	277	Prosthesis	229200000X
28	Laboratory	280	Independent Lab	291U00000X
28	Laboratory	281	Mobile Lab	261QR0208X
28	Laboratory	282	KDHE Lab Billing	291U00000X
28	Laboratory	283	Pathology Lab	291U00000X
29	X-Ray Clinic	290	Free Standing X-Ray Clinic	261QR0200X
29	X-Ray Clinic	291	Mobile X-Ray Clinic	335V00000X
29	X-Ray Clinic	292	Mammography	261QR0208X
29	X-Ray Clinic	293	Diagnostic X-Ray	261QR0200X
30	Renal Dialysis Center	300	Renal Dialysis Center	163WH0500X
31	Physician	150	Chiropractor	111N00000X
31	Physician	272	Oral Surgeon	1223S0112X
31	Physician	310	Allergist	207K00000X
31	Physician	311	Anesthesiologist	207L00000X
31	Physician	312	Cardiologist	207R00000X
31	Physician	313	Cardiovascular Surgeon	208G00000X
31	Physician	314	Dermatologist	207N00000X
31	Physician	315	Emergency Medicine Practitioner	207P00000X
31	Physician	316	Family Practitioner	208D00000X
31	Physician	317	Gastroenterologist	207RG0100X
31	Physician	318	General Practitioner	207Q00000X
31	Physician	319	General Surgeon	208600000X
31	Physician	320	Geriatric Practitioner	207QG0300X
31	Physician	321	Hand Surgeon	2086S0105X
31	Physician	322	Internist	207R00000X
31	Physician	323	Neonatologist	2080N0001X
31	Physician	324	Nephrologist	207RN0300X
31	Physician	325	Neurological Surgeon	207T00000X
31	Physician	326	Neurologist	2084N0400X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
31	Physician	327	Nuclear Medicine Practitioner	207U00000X
31	Physician	328	Obstetrician/Gynecologist	207V00000X
31	Physician	329	Oncologist	207RH0003X
31	Physician	330	Opthamologist	207W00000X
31	Physician	331	Orthopedic Surgeon	207X00000X
31	Physician	332	Otologist, Laryngologist, Rhinologist	207Y00000X
31	Physician	333	Pathologist	207ZP0105X
31	Physician	334	Pediatric Surgeon	2086S0120X
31	Physician	335	Maternal Fetal Medicine	2080N0001X
31	Physician	336	Physical Medicine and Rehabilitation Practitioner	208100000X
31	Physician	337	Plastic Surgeon	2086S0122X
31	Physician	338	Proctologist	208C00000X
31	Physician	339	Psychiatrist	2084P0800X
31	Physician	340	Pulmonary Disease Specialist	207RP1001X
31	Physician	341	Radiologist	2085R0202X
31	Physician	342	Thoracic Surgeon	208G00000X
31	Physician	343	Urologist	208800000X
31	Physician	344	General Internist	207R00000X
31	Physician	345	General Pediatrician	208000000X
31	Physician	347	Radiation Therapist	2085R0203X
31	Physician	348	Addiction Medicine	207QA0401X
31	Physician	349	Exempt License Physician	207Q00000X
31	Physician	350	Preventative Medicine	2083P0901X
31	Physician	351	Indian Health Services	207Q00000X
36	Personal Care Services	236	Screening	3747P1801X
36	Personal Care Services	360	Personal Care - Individual	3747P1801X
36	Personal Care Services	361	Personal Care - Agency	251J00000X
36	Personal Care Services	362	Family/Individual Supports	225C00000X
36	Personal Care Services	364	Residential Supports	3747P1801X
36	Personal Care Services	365	Supportive Home Care	3747P1801X
36	Personal Care Services	368	Sleep Cycle Support - MRDD	3747P1801X
36	Personal Care Services	502	Communication Devices	3747P1801X
36	Personal Care Services	512	Respite Care - MRDD	385H00000X
38	Respite Care	380	Respite Care - Community Based	3747P1801X
38	Respite Care	381	Respite Care - Home Based	3747P1801X
41	Adult Day	410	Adult Day Care	261QA0600X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Care			
42	Teaching Institution	010	Acute Care	282N00000X
42	Teaching Institution	011	Psychiatric	283Q00000X
42	Teaching Institution	012	Rehabilitation	283X00000X
43	Homemaker Services	430	Homemaker Services	376J00000X
43	Homemaker Services	510	Attendant Care - Level I	376J00000X
44	Home Modifications	440	Assistive Services	171WH0202X
44	Home Modifications	441	Assistive Technology Services	171WH0202X
44	Home Modifications	500	Assistive Services - PD	171WH0202X
44	Home Modifications	503	Assistive Services - HI	171WH0202X
45	QMB	450	QMB	101Y00000X
53	Head Start Facility	345	General Pediatrician	208000000X
55	HCBS	053	Respite Care Home and Community Based Services	251E00000X
55	HCBS	054	Waivered Case Management	251E00000X
55	HCBS	059	Independent Living Counseling	251E00000X
55	HCBS	170	Physical Therapist	225100000X
55	HCBS	171	Occupational Therapist	225X00000X
55	HCBS	173	Speech/Hearing Therapist	235Z00000X
55	HCBS	176	Alcohol and Drug Rehabilitation	103TR0400X
55	HCBS	177	Behavioral Therapy	103TR0400X
55	HCBS	178	Cognitive Therapy	103TR0400X
55	HCBS	236	Screening	3747P1801X
55	HCBS	237	Targeted Case Management	251B00000X
55	HCBS	252	Emergency Response - Installation	332B00000X
55	HCBS	253	Emergency Response - Rental	332B00000X
55	HCBS	256	Van Lifts	332BC3200X
55	HCBS	257	Wheelchair Modifications	3747P1801X
55	HCBS	268	Medical Alert	251E00000X
55	HCBS	360	Personal Care - Individual	3747P1801X
55	HCBS	362	Family/Individual Supports	225C00000X
55	HCBS	363	Personal Services - HI	251E00000X
55	HCBS	364	Residential Supports	3747P1801X
55	HCBS	365	Supportive Home Care	3747P1801X
55	HCBS	366	Night Support - HI	3747P1801X
55	HCBS	367	Personal Services - PD	251E00000X
55	HCBS	368	Sleep Cycle Support - MRDD	3747P1801X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
55	HCBS	369	Supported Employment Services - MRDD	372600000X
55	HCBS	370	Personal Assistant Services - MRDD	251S00000X
55	HCBS	410	Adult Day Care	261QA0600X
55	HCBS	440	Assistive Services	171WH0202X
55	HCBS	441	Assistive Technology Services	332B00000X
55	HCBS	500	Assistive Services - PD	332BC3200X
55	HCBS	502	Communication Devices	3747P1801X
55	HCBS	503	Assistive Services - HI	332BC3200X
55	HCBS	509	Medication Reminder	251E00000X
55	HCBS	510	Attendant Care - Level I	251E00000X
55	HCBS	511	Attendant Care - Level II	251E00000X
55	HCBS	512	Respite Care - MRDD	3747P1801X
55	HCBS	513	Sleep Cycle Support	251E00000X
55	HCBS	514	Wellness Monitoring - FE	251E00000X
55	HCBS	515	Nursing Evaluation	251E00000X
55	HCBS	516	Respite Care - FE	251E00000X
55	HCBS	517	Wellness Monitoring - MRDD	251E00000X
55	HCBS	518	Comprehensive Support Services - FE	372600000X
55	HCBS	520	Day Supports	251C00000X
55	HCBS	521	Specialized Medical Care RN/MRDD	163W00000X
55	HCBS	523	Specialized Medical Care LPN/MRDD	164W00000X
55	HCBS	540	Transitional Living Skill	225100000X
55	HCBS	550	Autism Specialist	171M00000X
55	HCBS	551	Intensive Individual Support - AU	222Q00000X
55	HCBS	552	Respite Care - AU	385HR2055X
55	HCBS	553	Parent Support - AU	222Q00000X
55	HCBS	554	Family Adjustment Counseling - AU	222Q00000X
55	HCBS	555	Case Management/Care Coordination/TA	171M00000X
55	HCBS	558	Personal Service Attendant/TA	3747P1801X
55	HCBS	559	Home Modifications/TA	171WH0202X
56	Work	506	Independent Living Counselor	251E00000X
56	Work	522	Assessment Service	225C00000X
56	Work	526	Assistive Services	332BC3200X
70	Data Access Entity	700	Eligibility Inquiry/Verification	251K00000X

ATTACHMENT L
Program Integrity and Disclosure Requirements

The CONTRACTOR shall diligently safeguard against the potential for, and promptly investigate reports of, suspected fraud and abuse by employees, subcontractors, providers, and others with whom the CONTRACTOR does business. The CONTRACTOR shall provide Kansas Department of Health and Environment / Division of Health Care Finance (KDHE/DHCF) with the CONTRACTOR'S policies and procedures on handling issues of suspected fraud and abuse.

The CONTRACTOR shall comply with all Federal and State Laws and Regulations related to program integrity and disclosure requirements. This includes any future laws and regulations that may be required as well as current laws and regulations.

Verification of Services Provided 42 CFR §455.20.
The CONTRACTOR shall have in place a method to verify whether services reimbursed by the CONTRACTOR were actually furnished to eligible persons as billed by providers.

Coordination of Program Integrity Efforts.
The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:

a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
    (1) Oversight of the program integrity function under this contract;
    (2) Liaison with the State in all matters regarding program integrity;
    (3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
    (4) Liaison with Kansas' MFCU;
    (5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

Procedures to Guard Against Fraud & Abuse 42 CFR §438.608.
The CONTRACTOR shall have administrative and management arrangements or procedures, and a mandatory compliance plan that are designed to guard against fraud and abuse and include the following:

a. Written policies, procedures, and standards of conduct consistent with all applicable Federal and State laws pertaining to fraud and abuse and that articulate the organizations commitment to complying with all applicable Federal and State standards. Attached hereto and incorporated herein by reference as Appendix 1 is a document entitled "*CMS Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit*," which was published by Centers for Medicare and Medicaid Services (CMS) in September 2008. The CONTRACTOR shall incorporate the guidance document and fraud referral performance standards, as well as any other appropriate guidance and/or future CMS guidance, into written policies and procedures and training materials on developing suspected Medicaid fraud cases for referral to appropriate authorities, including but not limited to MFCU. In any of the joint program integrity meetings held among the parties to this agreement, the parties shall jointly discuss the guidance document;
b. The designation of a compliance officer and a compliance committee who are accountable to senior management;
c. Effective training and education for the compliance officer and the staff;
d. Effective lines of communication between the compliance officer and staff;
e. Enforcement of standards through well-publicized disciplinary guidelines;
f. Provision for internal monitoring and auditing, and
g. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the contract services.

Obligation to Suspend Payments to Providers 42 CFR §455.23.
The CONTRACTOR shall comply with 42 C.F.R. § 455.23 by suspending all payments to a provider after the CONTRACTOR determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless KDHE/DHCF has identified in writing good cause for not suspending payments or to suspend payments only in part.

a. The CONTRACTOR shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 C.F.R. § 455.23(b) and maintain the suspension for the durational period set forth in 42 C.F.R. § 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 C.F.R. § 455.23;
b. Whenever the CONTRACTOR suspends payments in compliance with this subsection in whole or in part, the CONTRACTOR shall make a written fraud referral to Kansas' MFCU not later than the next business day after the suspension is enacted. Whenever possible, the CONTRACTOR should notify the MFCU of the potential suspension and afford the MFCU the opportunity to determine whether or not the suspension is appropriate before suspending payments;
c. The CONTRACTOR shall maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 C.F.R. § 455.23(g).

Reporting of Ownership & Control of CONTRACTOR 42 CFR §455.104.
The CONTRACTOR shall report ownership and control information:

a. *What disclosures must be provided*. The CONTRACTOR shall report the following:
    (1) The name and address of any person (individual or corporation) with an ownership or control interest in the CONTRACTOR. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
    (2) The date of birth and Social Security Number (in the case of an individual);
    (3) Other tax identification number (in the case of a corporation) with an ownership or control interest in the CONTRACTOR or in any subCONTRACTOR in which the CONTRACTOR has a 5% or more interest;
    (4) Whether the person (individual or corporation) with an ownership or control interest in the CONTRACTOR is related to another person with ownership or control interest in the CONTRACTOR as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subCONTRACTOR in which the disclosing entity has a 5% or more interest is related

to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

(5) The name of any other disclosing entity (or fiscal agent or managed care entity) in which the owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest;

(6) The name, address, date of birth, the Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

b. *When the disclosures must be provided*;

(1) Disclosures from the CONTRACTOR are due:

i. Upon the CONTRACTOR submitting the proposal in accordance with the State's procurement process.

ii. Upon the CONTRACTOR executing a contract with the State.

iii. Upon renewal or extension of the Contract.

iv. Within 35 days after any change in ownership of the CONTRACTOR.

c. *To Whom Must the Disclosures be Provided*. All disclosures must be provided to KDHE/DHCF.

d. *Consequences for Failure to Provide Required Disclosures*. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by law.

Reporting of Business Transactions of CONTRACTOR 42 CFR 455.105.

a. The CONTRACTOR shall furnish to KDHE/DHCF and/or the Secretary of Health and Human Services (HHS) on request, information related to business transactions in accordance with subparagraph (b) immediately below.

b. The CONTRACTOR must submit, within 35 days of the date on a request by the Secretary of HHS or KDHE/DHCF full and complete information about –

(1) The ownership of any subcontractor with whom the CONTRACTOR has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the CONTRACTOR and any wholly owned supplier, or between the provider and any subcontractor, during the five (5) year period ending on the date of the request.

c. FFP is not available in expenditures for services furnished by CONTRACTOR if the CONTRACTOR fails to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under 42 CFR §420.205. CONTRACTOR shall not be entitled to payment under the contract (i.e., no capitation payment will be paid) for services provided during the period beginning on the day following the date the information was due to the Secretary of HHS or KDHE/DHCF and ending on the day before the date on which the information was supplied.

CONTRACTOR Disclosure of Information on Persons Convicted of Crimes 42 CFR 455.106.

a. *Information that must be disclosed*. Upon signing this amendment and prior to renewal of the contract, or at any time upon written request by KDHE/DHCF, the CONTRACTOR must disclose to KDHE/DHCF the identity of any person who:

(1) Has ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) since the inception of those programs.

b. *Notification to Inspector General*.

(1) KDHE/DHCF must notify the Inspector General of the HHS of any disclosures made under paragraph (a) of this subsection within 20 working days from the date it receives the information.

(2) KDHE/DHCF will also promptly notify the Inspector General of HHS of any action it takes in respect to the CONTRACTOR.

c. *Denial or Termination of Contract*.

(1) KDHE/DHCF may refuse to enter into or renew a Contract with the CONTRACTOR if any person who has an ownership or control interest in the CONTRACTOR, or who is an agent or managing employee of the CONTRACTOR, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP.
(2) KDHE/DHCF may refuse to enter into or may terminate the Contract if it determines that the CONTRACTOR did not fully and accurately make any disclosure required under subparagraph (a) of this section.

CONTRACTOR Reporting Obligations for Adverse Actions Taken on Provider Applications for Program Integrity Reasons 42 CFR §455.1002.3.
The CONTRACTOR shall implement in its provider enrollment processes the obligation of providers to disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). CONTRACTOR shall forward such disclosures to KDHE/DHCF. CONTRACTOR shall abide by any direction provided CONTRACTOR on whether or not to permit the applicant to be a provider in the Kansas network. Specifically, the CONTRACTOR shall not permit the provider into the provider network if KDHE/DHCF or CONTRACTOR determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP, or if KDHE/DHCF or the CONTRACTOR determine that the provider did not fully and accurately make any disclosure required pursuant to 42 CFR § 1001.1001(a)(1).

Disclosure by CONTRACTOR Providers and Fiscal Agents: Information on Ownership and Control 42 CFR §455.104.

a. *Who must provide disclosures.* The CONTRACTOR must obtain disclosures from disclosing entities, fiscal agents, and network providers.
b. *What disclosures must be provided.* The CONTRACTOR must require that disclosing entities, fiscal agents, and network providers provide the following disclosures:
    (1) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or network provider. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
        ii. Date of birth and Social Security Number (in the case of an individual).
        iii. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network provider) or in any subcontractor in which the disclosing entity (or fiscal agent or network provider) has a 5% or more interest.
    (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network provider) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or network provider) has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
    (3) The name of any other disclosing entity (or fiscal agent or network provider) in which an owner of the disclosing entity (or fiscal agent or network provider) has an ownership or control interest.
    (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or network provider).
c. *When the disclosures must be provided.*
    (1) *Disclosures from network providers or disclosing entities*. Disclosure from any network provider or disclosing entity is due at any of the following times:
        i. Upon the network provider or disclosing entity submitting the provider application.
        ii. Upon the network provider or disclosing entity executing the provider agreement.

iii. Upon request of KDHE/DHCF during the re-validation of enrollment process.
iv. Within 35 days after any change in ownership of the disclosing entity or network provider.

(2) *Disclosures from fiscal agents*. Disclosures from fiscal agents are due at any of the following times:
i. Upon the fiscal agent submitting the proposal in accordance with the procurement process.
ii. Upon the fiscal agent executing the contract with the CONTRACTOR.
iii. Upon renewal or extension of the contract with a fiscal agent.
iv. Within 35 days after any change in ownership of the fiscal agent.

(3) *Disclosures from managed care entities*. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except Person Centered Case Managements (PCCMs) are due at any of the following times:
i. Upon the managed care entity submitting the proposal in accordance with the procurement process.
ii. Upon the managed care entity executing the contract with the CONTRACTOR.
iii. Upon renewal or extension of the contract.
iv. Within 35 days after any change in ownership of the managed care entity.

(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

d. *To whom must the disclosures be provided*. All disclosures must be provided to CONTRACTOR, who will make them available to KDHE/DHCF.

e. *Consequences for failure to provide required disclosures.* FFP is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

Disclosure by Providers: Information Related to Business Transactions 42 CFR §455.105.

a. *Provider agreements*. The CONTRACTOR must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

b. *Information that must be submitted*. A provider must submit, within 35 days of the date on a request by the Secretary, KDHE/DHCF, or the CONTRACTOR, full and complete information about—
(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five (5) year period ending on the date of the request.

c. *Denial of FFP.*
(1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary, KDHE/DHCF, or the CONTRACTOR under paragraph (b) of this section or under 42 CFR § 420.205 .
(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary, KDHE/DHCF, or the CONTRACTOR and ending on the day before the date on which the information was supplied.

Disclosure by Providers: Information on Persons Convicted of Crimes 42 CFR §455.106.

a. *Information that must be disclosed*. Before the CONTRACTOR enters into or renews a provider agreement, or at any time upon written request by KDHE/DHCF or the CONTRACTOR, the provider must disclose to the CONTRACTOR and KDHE/DHCF the identity of any person who:
(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XXI services program since the inception of those programs.

b. *Notification to Inspector General*.
   (1) The CONTRACTOR shall notify KDHE/DHCF of any disclosures made under paragraph (a) of this section within 10 working days from the date it receives the information. KDHE/DHCF will forward the information to the Office of Inspector General of HHS.
   (2) The CONTRACTOR must also promptly notify the KDHE/DHCF of any action it takes on the provider's application for participation in the program.

c. *Denial or termination of provider participation*.
   (1) The CONTRACTOR may refuse to enter into or renew an agreement with a provider and KDHE/DHCF may refuse to allow CONTRACTOR to renew or enter into such an agreement if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP.
   (2) The CONTRACTOR may refuse to enter into or may terminate a provider agreement and KDHE/DHCF may refuse to allow the CONTRACTOR to renew or enter into such an agreement if any of the three entities determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

Federal Database Checks 42 CFR §455.436. The CONTRACTOR must do all of the following:

a. Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.
b. Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the General Services Administration's Excluded Parties List System (EPLS), the Medicare Exclusion Database (the MED) and any such other databases as the Secretary of HHS may prescribe, including the national database of terminated providers.
c. Consult appropriate databases to confirm identity upon enrollment and reenrollment and check the LEIE, EPLS, the MED and any such other databases as the Secretary of HHS may prescribe, no less frequently than monthly.
d. Notify KDHE/DHCF within one (1) business day if an enrolled provider and any person with an ownership or control interest or who is an agent or managing employee of the provider has been excluded from participation or of other adverse actions. FFP is not available for any provider and any person with an ownership or control interest or who is an agent or managing employee of the provider that has been excluded.

Prohibition on Certain Relationships 42 CFR §438.610.

a. The CONTRACTOR may not knowingly have a relationship with the following:
   (1) an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549, or
   (2) an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of the regulation.
b. For the purposes of this section, "Relationship" is defined as follows:
   (1) a director, officer, or partner of the CONTRACTOR;
   (2) a person with beneficial ownership of 5% or more of the CONTRACTOR'S equity, or
   (3) a person with an employment, consulting or other arrangement with the CONTRACTOR for the provision of items and services that are significant and material to the CONTRACTOR's obligation under its contract with the State.

Other Requirements.
The CONTRACTOR shall not expend Medicaid funds for providers excluded by Medicare, Medicaid, or CHIP, as notified by KDHE/DHCF, except for emergency services.

The CONTRACTOR must require each individually contracted physician to have a unique identifier.

The CONTRACTOR shall report fraud and abuse information to KDHE/DHCF quarterly. The report will include the following to the extent such information is available:

a. the number of complaints of fraud and abuse made to KDHE/DHCF that warrant preliminary investigation, and
b. for each complaint which warrants investigation, the following information: name-ID number; source of complaint; type of provider; nature of complaint; approximate dollars involved; legal and administrative disposition of the case.

The CONTRACTOR shall document that safeguards at least equal to federal safeguards (at 41 USC 423, section 27) are in place.

Termination or Denial of Enrollment of Provider if Provider is terminated from any other State Medicaid Program or Medicare. 42CFR §455.416
The CONTRACTOR must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State. Providers terminated or denied under §455.416 must be given any appeal rights available under procedures established by State law or regulations.

Requirements of Section 6032 of the DRA. Any provider or provider entity, including the CONTRACTOR, that receives or makes $5 million in annual payments from KDHE/DHCF, must comply with Section 6032 of the Deficit Reduction Act as a condition of receiving payment. The $5 million amount will be based on paid claims, net of any adjustments to those claims. **It will be the responsibility of providers or provider entities, including the CONTRACTOR, to make the determination as to whether they meet the $5 million threshold.**

To comply with Section 6032 of the Deficit Reduction Act (DRA), the CONTRACTOR and providers must ensure that no later than January 1, 2007, it has implemented all of the following requirements:

a. Must establish written policies that provide detailed information about the Federal laws identified in Section 6032(A) and any Kansas laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws.
b. In addition to the detailed information regarding the Federal and State laws, the written policies must contain detailed information regarding the CONTRACTOR or provider's own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, including the Medicare and MA Programs.
c. The CONTRACTOR and providers must provide a copy of its written policies to all of its employees, contractors and agents of the vendor.
d. If the CONTRACTOR or providers maintain an employee handbook, the CONTRACTOR or provider must include in its employee handbook a specific discussion of the Federal and State laws described in its written policies, the provider's policies and procedures for detecting and preventing fraud, waste and abuse and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging fraud, waste or abuse in a Federal health care program, including the Medicare and KDHE/DHCF Programs, to the CONTRACTOR or provider or to the appropriate authorities.

Cost Recovery and Cost Avoidance Tracking and Reporting
The CONTRACTOR must submit a monthly report to KDHE/DHCF detailing, for the reporting month, the money saved and costs avoided through front end edits and recipient lock-in and other cost avoidance

efforts, and the amount recovered through fraud, waste or abuse detection efforts. These reports must be in a format approved by KDHE/DHCF.

APPENDIX 1
CMS-MIG Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit

Specification Category	Specification Details
Objective	Determine the percentage of acceptable referrals (those that meet minimum criteria for a "collection of information") that were provided by the State Medicaid agency to its Medicaid Fraud Control Unit (MFCU) in accordance with 42 CFR 455.21(a)(1).
Definitions	Referral: A "collection of information" communicated from the Single State Agency to the MFCU due to suspicion of provider fraud (in accordance with CFR) through a formalized process. *Acceptable Referral*: Referral of a potentially fraudulent Medicaid provider to the State's MFCU that contains the "minimum criteria." Minimum Criteria for "collection of information" provided to allow the MFCU to determine if further action is warranted includes: • Subject (name, Medicaid ID, address, provider type) • Source/origination of complaint • Date reported to State • Description of suspected misconduct, with specific details including: - Category of service - Factual explanation of the allegation - Specific Medicaid statutes, rules, regulations, and/or policies violated - Date(s) of conduct • Amount paid to provider during the past 3 years or during the period of the alleged misconduct, whichever is greater • All communications between State and provider concerning conduct at issue • Contact information for State agency staff person with practical knowledge of workings of the relevant program • Sample/exposed dollar amount [when available]
Data Source	State Program Integrity Assessment (SPIA) Data Collection Instrument

Specification Category	Specification Details
Unit of Analysis	Referrals to MFCUs
Frequency of Measurement	Annually by FFY beginning with FFY 2009; Validation of 1/3 of States annually through Medicaid Program Integrity Reviews
Formula	Identify percentage of acceptable referrals: Numerator = # of acceptable referrals provided to MFCUs Denominator = total # of referrals sent to MFCUs