

LIST OF ATTACHMENTS

No. Title of Attachments

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*Forms Provided

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* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

TN No. MS-91-47 Approval Date FEB 19 1992 Effective Date 10/01/91
Supersedes
TN No. MS-91-41

HCFA ID: 7982E

<u>No.</u>	<u>Title of Attachment</u>
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
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*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
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*Forms Provided

<u>No.</u>	<u>Title of Attachment</u>
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7.2-A	Methods of Administration - Civil Rights (Title VI)

*Forms Provided

TN No. MS-91-47
Supersedes
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Effective Date 10/01/91

HCFA ID: 7982E

STATE OF KANSAS

93-11



OFFICE OF THE GOVERNOR
State Capitol
Topeka 66612

John Carlin Governor

May 3, 1983

Dr. Robert C. Harder
Secretary of Social and
Rehabilitation Services
State Office Building
Topeka, Kansas 66612

Dear Secretary Harder:

This will acknowledge that the Office of the Governor has reviewed the fifteen revised pages to the Title XIX Kansas State Plan for Medical Assistance.

Thank you for bringing this to my attention.

Sincerely,

A large, stylized handwritten signature of John Carlin in black ink.

JOHN CARLIN
Governor

RCH:mao
1140E

STATE DEPT. OF
SOC. REHAB. SERV.

MAY 2 1983

RECEIVED
SECRETARY'S OFF.

Revision: HCFA-PM-91-4
August 1991

(BPD)

OMB No. 0938-

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM**

State/Territory: Kansas

Citation As a condition for receipt of Federal funds under
Title XIX of the Social Security Act, the

42 CFR
430.10

Kansas Health Policy Authority
(Single State Agency)

submits the following State plan for the medical
assistance program, and hereby agrees to administer
the program in accordance with the provisions of this
State plan, the requirements of titles XI and XIX of
the Act, and all applicable Federal regulations and
other official issuances of the Department.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kansas

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The Kansas Health Policy Authority

is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph).

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

Yes. The State agency so designated is

_____.
This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

TN # 77-4
Supersedes
TN # MS-77-4

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
Intergovernmental
Cooperation Act
of 1968

1.1(c) Waivers of the single State agency
requirement which are currently
operative have been granted under
authority of the Intergovernmental
Cooperation Act of 1968.

Yes. ATTACHMENT 1.1-B describes
these waivers and the approved
alternative organizational
arrangements.

Not applicable. Waivers are no
longer in effect.

Not applicable. No waivers have
ever been granted.

TN # 77-4
Supersedes
TN # 48-77-4

Approval Date 8-19-77 Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.10
AT-79-29

- 1.1(d) The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
- Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

TN # 77-4
Supersedes
TN # MS-77-4

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.10
AT-79-29

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

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TN # MS-77-4

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.11
AT-79-29

1.2 Organization for Administration

- (a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.
- (b) Within the State agency,

Kansas Health Policy Authority has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance units and organization chart of the Authority.
- (c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.
- (d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make sure determinations and the functions they will perform.

_____ Not applicable. Only staff of the agency Named in paragraph 1.1(a) make such determination.

Revision: HCFA-AT-80-38 (BFP)
May 22, 1980

State KANSAS

Citation
42 CFR
431.50 (b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

- The plan is State administered.
- The plan is administered by the political subdivisions of the State and is mandatory on them.

TN # 77-4
Supersedes
TN # _____

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kansas

Citation
42 CFR
431.12(b)
AT-78-90

1.4 State Medical Care Advisory Committee
There is an advisory committee to the Medicaid
agency director on health and medical care
services established in accordance with and
meeting all the requirements of 42 CFR 431.12.

42 CFR
438.104

X The State enrolls recipients in MCO, PIHP, PAHP,
and/or PCCM programs. The State assures that it
complies with 42 CFR 438.104(c) to consult
with the Medical Care Advisory Committee
in the review of marketing materials.

TN # #03-28
Supersedes TN # #77-04

Effective Date August 1, 2003 October 1, 2003
Approval Date December 15, 2003

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State: Kansas

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and
Furnishing Medicaid

- (a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
 Supersedes _____
 TN No. _____

HCFA ID: 7982E

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM- (MB)

State/Territory: Kansas

Citation

42 CFR
435.914
1902(a)(34)
of the Act

2.1(b) (1) Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

1902(e)(8) and
1905(a) of the
Act

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

1902(a)(47) and

_____ (3) Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

42 CFR
438.6

(c) The Medicaid agency elects to enter into a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

- _____ Qualified under title XIII 1310 of the Public Health Service Act.
- X a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
- X a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
- X a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2
- _____ Not applicable.

TN # #03-08
Supersedes TN # 95-23

Effective Date August 1, 2003
Approval Date August 28, 2003

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.

State/Territory: KansasCitation1902(a)(55)
of the Act

2.1(d)

The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in S1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(II)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

TN No. MS-91-47

Supersedes

TN No. MS-91-39Approval Date FEB 19 1992Effective Date 10/01/91

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State: Kansas

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in
ATTACHMENT 2.2-A.

- Mandatory categorically needy and other required special groups only.
- Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- Mandatory categorically needy, other required special groups, and specified optional groups.
- Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

TN No. MS-91-41

Supersedes

TN No. MS-91-11

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7982E

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: KANSAS

Citation

435.10 and
435.403, and
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

TN No. MS-87-18

Supersedes

TN No. MS-86-37

Approval Date 6/16/87

Effective Date 7-1-87

HCFA ID: 1006P/0010P

Revision: HCFA-PM-87-4
MARCH 1987

(BERC)

OMB: No.: 0938-0193

State: KANSAS

Citation 2.4 Blindness

42 CFR 435.530(b)
42 CFR 435.531
AT-78-90
AT-79-29

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Section 1902(v)
42 U.S.C. Sec.
1396a(v)

A determination of blindness is made by the State for the purpose of determining eligibility for medical assistance under the State Plan and to make medical assistance available to individuals found to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. The definition of blindness found in Section 1614(a) of the Social Security Act is used to make such determination.

SEP 08 2006

TN No. MS #06-05 Approval Date _____ Effective Date 09/01/06 Supersedes TNMS 87-18

Revision: HCFA-PM-91- (BPD)
1991

OMB No. 0938-

State: KANSAS

Citation

2.5 Disability

42 CFR
435.121,
435.540(b)
435.541

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

Section 1902(v)
42 U.S.C. Sec.
1396a(v)

A determination of disability is made by the State for the purpose of determining eligibility for medical assistance under the State Plan and to make medical assistance available to individuals found to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. The definition of disability found in Section 1614(a) of the Social Security Act is used to make such determination.

SEP 08 2006

TN No. MS #06-05 Approval Date _____ Effective Date 09/01/06 Supersedes TNMS 92-08

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: KANSAS

Citation(s)

2.6 Financial Eligibility

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

- (a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

TN No. MS-92-09

Supersedes MS-91-41 Approval Date

JUN 01 1992

Effective Date 1-1-92

TN No. MS-91-41

Agency*	Citation(s)	X 13.	Groups Covered
** XIX	1902(a)(10) (A)(ii)(IX) and 1902(1) of the Act, P.L. 99-509 (Sections 9401(a) and (b))	X 13.	The following individuals who are not described in section 1902(a)(10)(A)(I) of the Act whose income level (established at an amount up to 150 percent of the Federal nonfarm poverty line) specified in Supplement 1 to <u>ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and infant or child who meet the resource standards specified in Supplement 2 to <u>ATTACHMENT 2.6-A</u> : (a) Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age (effective April 1, 1987); — (b) Children who have attained one year of age but not attained two years of age (effective October 1, 1987); — (c) Children who have attained two years of age but not attained three years of age (effective October 1, 1988); — (d) Children who have attained three years of age but not attained four years of age (effective October 1, 1989); X (e) Children who have attained five years of age but not attained six years of age whose family income does not exceed 133 percent of the Federal nonfarm poverty line. Infants and children covered under items 13 (a) through (e) above who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished. Pregnant women covered under item 13(a) shall continue to be eligible regardless of any changes in income.

Section 4603 of
P.L. 101-508

*Agency that determines eligibility for coverage.

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

OMB-No. 0938-0193

State/Territory: KansasCitation

431.52 and
1902(b) of the
Act, P.L. 99-272
(Section 9529)

2.7

Medicaid Furnished Out of State

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

TN NO. MS-86-38
Supersedes
TN NO. MS-82-26

Approval Date Dec 17, 86Effective Date 10/01/86

HCFA ID:0053C/0061E

Revision: HCFA-PM-94-5
April 1994

19
(MB)

State/Territory: Kansas

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

42 CFR
part 440
Subpart B
1902(a), 1902(e)
1905(a), 1905(p),
1915, 1920, and
1925 of the Act

1902(a)(10)(A) and
1905(a) of the Act

3.1 Amount, Duration, and Scope of Services

- (a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

- (i) Each item or services listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
- (ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

--- Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 3.1(a)(1) Amount, Duration, and Scope of Services:
Categorically Needy (Continued)

1902(e)(5) of
the Act

(iii) Pregnancy-related, including family
planning services, and postpartum
services for a 60-day period
(beginning on the day pregnancy ends)
and any remaining days in the month in
which the 60th day falls are provided to
women who, while pregnant, were eligible
for, applied for, and received medical
assistance on the day the pregnancy ends.

X/ (iv) Services for medical conditions that may
complicate the pregnancy (other than
pregnancy-related or postpartum services)
are provided to pregnant women.

1902(a)(10),
clause (VII)
of the matter
following (E)
of the Act

(v) Services related to pregnancy (including
prenatal, delivery, postpartum, and family
planning services) and to other conditions
that may complicate pregnancy are the same
services provided to poverty level pregnant
women eligible under the provision of
sections 1902(a)(10)(A)(i)(IV) and
1902(a)(10)(A)(ii)(IX) of the Act.

TN No. MS-91-41

Supersedes

TN No. MS-90-19

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7982E

Revision: HCFA-PM-91- (BPD)
1991

OMB No.: 0938-

State/Territory: Kansas

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, (a)(2) Medically needy.
Subpart B

This State plan covers the medically needy.
The services described below and in ATTACHMENT
3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv)
of the Act
42 CFR 440.220

- (i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of
the Act

- (ii) Prenatal care and delivery services for pregnant women.

TN No. MS-92-08

Supersedes Approval Date MAY 22 1992

Effective Date JAN 01 1992

Replaces MS-91-41

HCFA ID: 7982E

HCFA-PM-91-
1991

(BPD)

OMB No.: 0938-

State/Territory: Kansas

Citation 3.1(a)(2) Amount, Duration, and Scope of Services:
Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

(vii) Services in an institution for mental diseases for individuals over age 65..

(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21.

42 CFR 440.140,
440.150, 440.160
Subpart B,
442.441,
Subpart C
1902(a)(20)
and (21) of the Act

TN No. MS-92-08

Supersedes

Approval Date

MAY 22 1992

Effective Date

JAN 01 1992

TN No. MS-91-41

HCFA ID: 7982E

KANSAS MEDICAID STATE PLAN

20b

Revision: HCFA-PM-93-5 (MB)
May 1993

State/Territory: Kansas

Citation

3.1(a)(2) Amount, Duration, and Scope of
Services: Medically Needy (Continued)

1902(e)(9) of the Act

- _____ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in items 3.1(h) of this plan.

1905(a)(23)
and 1929 of the Act.

- _____ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of Kansas

Citation: 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1905(a)(26) and 1934

- (xii) X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage-that is in excess of established service limits-for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this is not applicable for this program.)

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Kansas

Citation 3.1 Amount, Duration, and Scope of Services (continued)

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

1902(a)(10)(E)(ii) and 1905(s) of the Act

(a)(4)(i) Other Required Special Groups: Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.

1902(a)(10)(E)(iv)(I) 1905(p)(3)(A)(ii), and 1933 of the Act

(iii) Other Required Special Groups: Qualifying Individuals - 1

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

State/Territory: KansasCitation 3.1 Amount, Duration, and Scope of Services – (Continued)

1902(a)(10)
 (E)(iv)(II), 1905(p)(3)
 (A)(iv)(II), 1905(p)(3)
 the Act

(iv) Other Required Special Groups: Qualifying Individuals – 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying Individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the
 Act

(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families Described in section 1925 of the Act are Provided as indicated in item 3.5 of this plan.

1902(a) and 1903(v)
 of the Act and
 Section 401(b)(1)(A)
 Of P.L. 104-193

(a)(6) Limited Coverage for Certain Aliens

An alien who is not a qualified alien or who is a qualified alien, as defined in section 431(b) of P.L. 104-193, but is not eligible for Medicaid based on alienage status, and who would otherwise qualify for Medicaid is provided Medicaid only for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State/Territory: Kansas

Citation

1905(a)(9) of 3.1 (a)(7) Homeless Individuals
the Act

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902(a)(47) (a)(8) Presumptively Eligible Pregnant Women
and 1920 of
the Act

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

42 CFR 441.55
50 FR 43654
1902(a)(43),
1905(a)(4)(B),
and 1905(r) of
the Act

(a)(9) EPSDT Services

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. MS-97-08

Supersedes

Approval Date

MAY 01 1997

Effective Date 1-1-97

TN No. MS-92-08

HCFA ID: 7982E

Revision: HCFA-PM-91-
1991

(BPD)

OMB No.: 0938-

State: KansasCitation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT
Services (continued)42 CFR 441.60 / The Medicaid agency has in effect agreements with continuing care
providers. Described below are the methods employed to assure the
providers' compliance with their agreements.**42 CFR 440.240 (a)(10) Comparability of Services
and 440.2501902(a) and 1902
(a)(10), 1902(a)(52),
1903(v), 1915(g),
1925(b)(4), and 1932
of the ActExcept for those items or services for which sections
1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the
Act, 42 CFR 440.250, and section 245A of the
Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
- / (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

TN # #03-08
Supersedes TN # 92-08Effective Date August 1, 2003
Approval Date August 28, 2003

State of Kansas

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued) 1905(a)(26) and 1934

(vi) Home Health services are provided to individuals entitled to nursing facility services are indicated in item 3.1(b) of this plan.

1902(e)(7) of the Act (vii) Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or in section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State Plan will continue until the end of the stay for which the inpatient services are furnished.

1902(e)(9) of the Act (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1902(a)(52) and 1925 of the Act (ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

1905(a)(23) (x) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

1905(a)(26) and 1934 of the Act (xi) Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage-that is in excess of established service limits-for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-AT-80-38 (BPP)
 May 22, 1980

State KANSAS

Citation
 42 CFR Part
 440, Subpart B
 42 CFR 441.15
 AT-78-90
 AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

- (1) Home health services are provided to all categorically needy individuals 21 years of age or over.
- (2) Home health services are provided to all categorically needy individuals under 21 years of age.

Yes

Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

- (3) Home health services are provided to the medically needy:

Yes, to all

Yes, to individuals age 21 or over; SNF services are provided

Yes, to individuals under age 21; SNF services are provided

No; SNF services are not provided

Not applicable; the medically needy are not included under this plan

179 does not agree w/ pg# critique

TN # 80-8
 Supersedes
 TN # _____

Approval Date 9/5/80
~~7-10-80~~

Effective Date 7-1-80
~~9-5-80~~

Revision: HCFA-PM-93- (BPD)

State/Territory: KansasCitation 3.1 Amount, Duration, and Scope of Services (continued)42 CFR 431.53 (c) (1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c) (2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure
Quality of Services

The standards established and the
methods used to assure high quality
care are described in ATTACHMENT 3.1-C.

TN # 274-175
Supersedes
TN # 774

Approval Date 11-22-77
~~8-19-77~~

Effective Date 2-1-77

Revision: HCFA-AT-80-38 (BPP)
May-22, 1980

State KANSAS

Citation
42 CFR 441.20
AT-78-90

3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN # 224 78-1
Supersedes
TN # 775

Approval Date 5/24/78
8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 441.30
AT-78-90

3.1(f) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

Yes

No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

Not applicable. The conditions in the first sentence do not apply.

TN # 22-478-1
Supersedes
TN # 775

Approval Date 5/24/78
8-19-77

Effective Date 7-1-77

Revision: HCFA-PM-87-4 (BERG)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of
the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--
 - 30 consecutive days;
 - ___ days (the maximum number of inpatient days allowed under the State plan);
- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) Wish to be cared for at home.

Yes. The requirements of section 1902(e)(9) of the Act are met.

Not applicable. These services are not included in the plan.

TN No. MS-87-22

Supersedes

TN No. no transmittal number

Approval Date Sept 1, 87

Effective Date 4/1/87

HCFA ID: 1008P/0011P

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM-93-5 (MB)
May 1993

State/Territory: Kansas

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and
1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

_____ Part A X Part B

_____ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Kansas

Citation

1902(a)(10)(E)(ii)
and 1905(s) of the Act

(ii) Qualified Disabled and Working
Individual (ODWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the ODWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii)
and 1905(p)(3)(A)(ii)
of the Act

(iii) Specified Low-Income Medicare
Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I),
1905(p)(3)(A)(ii), and
1933 of the Act

(iv) Qualifying Individual-1
(OI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II),
1905(p)(3)(A)(ii), and
1933 of the Act

(v) Qualifying Individual-2
(OI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Kansas

Citation

1843(b) and 1905(a)
of the Act and
42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

X Individuals receiving title II or Railroad Retirement benefits.

X Medically needy individuals (FFP is not available for this group).

1902(a)(30) and
1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

KANSAS MEDICAID STATE PLAN

29c

Revision: HCFA-PM- - (MB)

State/Territory: Kansas

Citation (b) Deductibles/Coinsurance

1902(a)(30),
1902(n), 1905(a),
and 1916 of the Act

(1) Medicare Part A and B

Supplement 1 to ATTACHMENT 4.19-B
describes the methods and standards for establishing
payment rates for services covered under Medicare and/
or the methodology for payment of Medicare deductible
and coinsurance amounts, to the extent available for
each of the following groups.

Sections 1902
(a)(10)(E)(i) and
1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part
B deductible and coinsurance amounts for QMBS
(subject to any nominal Medicaid copayment) for
all services available under Medicare.

1902(a)(10),
1902(a)(30),
and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services
also covered under Medicare and furnished to
recipients entitled to Medicare (subject to any
nominal Medicaid copayment). For services
furnished to individuals who are described in
section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

_____ For the entire range of services available
under Medicare Part B.

X Only for the amount, duration, and scope of
services otherwise available under this
plan.

1902(a)(10)
1902(a)(30),
1905(a), and 1905(p)
of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part
B deductible and coinsurance amounts for all
services available under Medicare and pays for all
Medicaid services furnished to individuals
eligible both as QMBs and categorically or
medically needy (subject to any nominal Medicaid
copayment).

Revision: HCFA-PM-9-8 (MB)
October 1991

OMB No.:

State/Territory: Kansas

Citation

Condition or Requirement

1906 of the
Act

(c) Premiums, Deductibles, Coinsurance
and Other Cost Sharing Obligations

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).

1902(a) (10) (F)

(d) The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

TN No. MS-91-47

Supersedes Approval Date FEB 19 1992

TN No. MS-91-11

Effective Date 10/01/91
HCFA ID: 7983E

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 441.101,
42 CFR 431.620 (c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in
Institutions for Mental Diseases

Medicaid is provided for individuals 65 years
of age or older who are patients in
institutions for mental diseases.

Yes. The requirements of 42 CFR Part 441,
Subpart C, and 42 CFR 431.620 (c) and (d)
are met.

Not applicable. Medicaid is not provided
to aged individuals in such institutions
under this plan.

TN # 77-4
Supersedes
TN # _____

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 441.252
AT-78-99

3.4 Special Requirements Applicable to
Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F
are met.

179 does not show pg #, but same topic

TN # 78-14
Supersedes
TN # 77-4

Approval Date 4-3-79

Effective Date 3-8-79

State: Kansas

Citation 3.5 Families Receiving Extended Medicaid Benefits

1902(g) (52)
and 1925 of
the Act

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 are equal in amount, duration and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are

Equal in amount, duration and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

Equal in amount, duration and scope to services provided to categorically needy AFDC recipients (or may be greater if provided through a caretaker relative employer's health insurance plan), minus any one or more of the following acute services:

Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Medical or remedial care provided by licensed practitioners.

Home health services.

Private duty nursing services

Physical therapy and related services.

Other diagnostic, screening, preventive and rehabilitation services.

31c

Revision: HCFA-PM-91-4 (BPD)

OMB No.: 0938-

State: Kansas

- Enrollment in the State health plan for the uninsured.
- Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

- 2. The agency
 - (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).
 - (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

3.6 Unemployed Parent

For the purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency

- uses the standard for measuring unemployment which was in the AFDC State plan in effect on July 16, 1996.
- uses the following more liberal standard to measure unemployment:

An individual will be considered unemployed if the family's countable income as determined for the group defined in section 1931 is below the eligibility standard used for that group (Attachment 2.6-A, Supplement 12 and Supplement 1 to Attachment 2.6-A, Item A-1) or if the family's income minus deductions allowed for the medically needy, including incurred medical expenses, is less than medically needy income level (Supplement 1 to Attachment 2.6-A, Item D).

(NOTE: This effectively eliminates the old AFDC deprivation requirements from all groups.)

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State: Kansas

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

- (2) The agency--
- (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).
 - (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

TN No. MS-91-41

Supersedes

TN No. MS-90-19

Approval Date JAN 1 1991

Effective Date OCT 0 1 1991

HCFA ID: 7982E

Revision: HCFA-PM-87-4 (BERG)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Kansas

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

No. MS-87-22

recedes

. no transmittal number

Approval Date Sept 1, 87

Effective Date 4/1/87

HCFA ID: 1010P/0012F

Revision: HCFA RO VII
November 1990

State Kansas

Citation

4.2 Hearings for Applicants and Recipients

42 CFR 431.202
AT-79-29
AT-80-34

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

1919(e)(3)

With respect to transfers and discharges from nursing facilities, the requirements of 1919(e)(3) are met.

TN# MS-91-02

Approval Date

03/14/91

Effective Date

01/01/91

Supersedes

TN# No transmittal number

Revision: HCFA-AT-87-9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

State/Territory: KANSAS

Citation
42 CFR 431.301
AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

TN No. MS-87-36

Supersedes

TN No. no transmittal number

Approval Date

10/29/87

Effective Date

10/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-4 (BERG)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation

42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of
the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

Yes.

Not applicable. The State has an approved Medicaid Management Information System (MMIS).

(MS7-14)

TN No. MS-87-22
Supersedes
TN No. MS-85-49

Approval Date Sept 1, 87

Effective Date 4/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Kansas

Citation
42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TN No. MS-88-36

Supersedes

TN No. No transmittal number

Approval Date 12/21/88

Effective Date 10/1/88

HCFA ID: 1010P/0012P

New: HCFA-PM-99-3
JUNE 1999

State: Kansas

Citation

4.5a Medicaid Agency Fraud Detection and Investigation

Section 1902(a)(64) of
the Social Security Act
P.L. 105-33

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN # 01-06 Approval Date MAY 03 2001 Effective Date April 1, 2001 Supersedes None

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

179 does not comply w/ topic

TN # 77-6
Supersedes
TN # _____

Approval Date 1/27/78 Effective Date 1-1-78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN # 77-6
Supersedes
TN #

Approval Date 1/27/78

Effective Date 1-1-78

179 does not show pg # / topic

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN #

Supersedes

TN # 111A-77-6

Approval Date

8-19-77

Effective Date

7-1-77

Revision: HCFA-AT-80-38 (BFP)
May 22, 1980

State KANSAS

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 774
Supersedes
TN # US-77-4

Approval Date 8-19-77

Effective Date 7-1-77

New: HCFA-PM-99-3
JUNE 1999

State: Kansas

Citation

42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Section 1902(a)(23)
Of the Social
Security Act
P.L. 105-33

Section 1932(a)(1)
Section 1905(t)

TN # #03-08
Supersedes TN # 01-06

Effective Date August 1, 2003
Approval Date August 28, 2003

Revision: CMS-AT-80-38 (BPP)
May 22, 1980

State Kansas

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

- (a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is State Department of Health and Environment for hospital based long-term care units (K.S.A. 65-425a) and the Kansas Department on Aging for adult care homes (K.S.A. 39-923).
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): State Department of Health and Environment for hospital based long-term care units (K.S.A. 65-425a) and the Kansas Department on Aging for adult care homes (K.S.A. 39-923).
- (c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.610
AT-78-90
AT-89-34

4.11(d) The State Department of Health and Environment (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

TN #

Supersedes

TN #

77-4
65-77-4

Approval Date

8-19-77

Effective Date

7-1-77

HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

Yes, as listed below:

Not applicable. Similar services are not provided to other types of medical facilities.

TN # 77-4
Supersedes
TN # 48-77-4

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- 42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
- 42 CFR Part 483
1919 of the
Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
- 42 CFR Part 483,
Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
- 1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

X Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

TN No. MS-91-41
Supersedes Approval Date JAN 27 1992 Effective Date OCT 8 1991
TN No. MS-87-22

HCFA ID: 7982E

State/Territory: Kansas

Citation

1902 (a)(58)

1902(w)

4.13 (e)

For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

State/Territory: Kansas

statutory or recognized by the courts) concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
- (a) Hospitals at the time an individual is admitted as an inpatient.
 - (b) Nursing facilities when the individual is admitted as a resident.
 - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
 - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
 - (e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: Kansas

Citation 4.14
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

 Directly

 X By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

- (1) Meets the requirements of §434.6(a);
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the services and providers subject to PRO review;
- (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
- (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2)
and 1902(d) of the
ACT, P.L. 99-509
(section 9431)

 X A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation

TN # #03-08
Supersedes TN # None

Effective Date August 1, 2003
Approval Date August 28, 2003

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: _____

KANSAS

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14

(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

All hospitals (other than mental hospitals).

Those specified in the waiver.

No waivers have been granted.

TN No. MS-85-42
Supersedes
TN No. ~~70-24~~

Approval Date Sept 10, 85

Effective Date July 1, 85

HCFA ID: 0048P/0002P

Revision: HCFA-PH-85-7 (BERC)
 JULY 1985

OMB NO.: 0938-0193

State/Territory: Kansas

Citation
 42 CFR 456.2
 50 FR 15312

4.14

(c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals...

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

All mental hospitals.

Those specified in the waiver.

No waivers have been granted.

Not applicable. Inpatient services in mental hospitals are not provided under this plan.

TN No. MS-85-49
 Supersedes
 TN No. 76-4
85-43

Approval Date

10/18/85

Effective Date

7/1/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: KANSAS

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.

TN No. MS-85-44

Supersedes

TN No. ~~76-4~~

Approval Date Sept 10, 85

Effective Date July 1, 85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERG)
 May 1985

State: KANSAS

OMB NO. 0938-0193

Citation
 42 CFR 456.2
 50 FR 15312

4.14 (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

Facility-based review.

Direct review by personnel of the medical assistance unit of the State agency.

Personnel under contract to the medical assistance unit of the State agency.

Utilization and Quality Control Peer Review Organizations.

Another method as described in ATTACHMENT 4.14-A.

Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Kansas

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)

For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354

42 CFR 438.356(b) and (d)

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

___ Not applicable.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: KANSAS

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part
456 Subpart
I, and
1902(a)(31)
and 1903(g)
of the Act

___ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

___ ICFs/MR;

___ Inpatient psychiatric facilities for recipients under age 21; and

___ Mental Hospitals.

42 CFR Part
456 Subpart
A and
1902(a)(30)
of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

___ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

___ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

___ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN No. MS-92-12 Approval Date MAY 18 1992 Effective Date MAY 01 1992
Supersedes _____
TN No. NO Transmittal No. _____

HCFA ID: _____

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.615 (c)
AT-78-90

4.16 Relations with State Health and Vocational
Rehabilitation Agencies and Title V
Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN # 77-4
Supersedes
TN # RS 77-4

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Citation 4.17 Liens and Adjustments or Recoveries
42 CFR 433.36(c)
1902(a) (18) and
1917(a) and (b) of
the Act

(a) Liens

The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

The State imposes liens on real property on account of benefits incorrectly paid.

X _____

The State imposes TEFRA liens 1917(a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements).

The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently, institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2) _____ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a) (1) (B) (even if it does not impose those liens).

- (3) _____ For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

All services, except when provided to beneficiaries who have only received such services as a low income Medicare beneficiary eligible for Medicare copayments and/or deductibles only.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

- (4) The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.
- The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries).
- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.
- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:
- If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

1917 (b) 1 (C)

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR §433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
 - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
 - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No more money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN #04-09 Approval Date **DEC 13 2004** Effective Date 07/01/04 Supersedes TN # None

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
 - estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b) (3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
 - individual's home,
 - equity interest in the home,
 - residing in the home for at least 1 or 2 years,
 - on a continuous basis,
 - discharge from the medical institution and return home, and
 - lawfully residing.

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Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

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Revision: HCFA-AT-91-4(BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51

through 447.58 (a)

Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) (b)
of the Act

Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

- (1) No enrollment fee, premium, or similar charge is imposed under the plan.
- (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
 - (i) Services to individuals under age 18, or under--
 - Age 19
 - Age 20
 - Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

- (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

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AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
through
447.58

- (iii) All services furnished to pregnant women.
women.
- Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

- Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.
- Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act,
P.L. 99-272,
(Section 9505)

- (viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

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AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18(b) (Continued)

42 CFR 447.51
through
447.48

- (3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

Not applicable. No such charges are imposed.

- (i) For any service, no more than one type of charge is imposed.
- (ii) Charges apply to services furnished to the following age groups:

18 or older

19 or older

20 or older

21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

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Supersedes

TN No. MS-86-40

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AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18(b)(3) (Continued)
42 CFR 447.51
through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

- (A) Service(s) for which a charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

Not applicable. There is no maximum.

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Supersedes
TN No. MS-90-19

HCFA ID: 7982E

Replacement Page dated 01-21-92.

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OMB No.: 0938-

State/Territory: Kansas

<p><u>Citation</u> 1916(c) of the Act</p>	<p>4.18(b)(4) <input type="checkbox"/></p>	<p>A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. <u>ATTACHMENT 4.18-D</u> specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.</p>
<p>1902(a)(52) and 1925(b) of the Act</p>	<p>4.18(b)(5) <input type="checkbox"/></p>	<p>For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.</p>
<p>1916(d) of the Act</p>	<p>4.18(b)(6) <input type="checkbox"/></p>	<p>A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. <u>ATTACHMENT 4.18-E</u> specifies the method and standards the State uses for determining the premium.</p>

TN No. MS-91-41

Supersedes

TN No. MS-86-40

Approval Date

JAN 27 1991

Effective Date

OCT 01 1991

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18(c) Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

TN No. MS-91-41

Supersedes

Approval Date _____

Effective Date 01-01-1991

TN No. MS-86-40

HCFA ID: 7982E

Replacement Page dated 01-21-92.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18 (c)(2) (Continued)

42 CFR 447.51
through
447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act,
P.L. 99-272
(Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through
447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

Not applicable. No such charges are imposed.

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
Supersedes
TN No. MS-86-40

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

// Not applicable. No such charges are imposed.

- (i) For any service, no more than one type of charge is imposed.
- (ii) Charges apply to services furnished to the following age group:

/X/ 18 or older

// 19 or older

// 20 or older

// 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.18(c)(3) (Continued)

- 447.51 through (iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:
- 447.58
- (A) Service(s) for which charge(s) is applied;
 - (B) Nature of the charge imposed on each service;
 - (C) Amount(s) of and basis for determining the charge(s);
 - (D) Method used to collect the charge(s);
 - (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
 - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
 - (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

X Not applicable. There is no maximum.

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
 Supersedes
 TN No. MS-86-40

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of
42 CFR Part 447, Subpart C, and sections
1902(a)(13) and 1923 of the Act with respect to
payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and
standards used to determine rates for payment for
inpatient hospital services.

Inappropriate level of care days are covered
and are paid under the State plan at lower
rates than other inpatient hospital services,
reflecting the level of care actually
received, in a manner consistent with section
1861(v)(1)(G) of the Act.

Inappropriate level of care days are not
covered.

TN No. MS-91-41
Supersedes MS-87-22
Approval Date JAN 2 1991 Effective Date JUL 9 1991
HCFA ID: 7982E

Revision: HCFA-PM-93-6 (MB)
August 1993

OMB No.: 0938-

State/Territory: Kansas

Citation
42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902(a)(13)(E)
1903(a)(1) and
1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (1), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and
1902(a)(30) of
the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

Yes. The State's policy is described in ATTACHMENT 4.19-C.

No.

TN # 77-6 no match w/179 per PG #, same topic
Supersedes Approval Date 1-27-78 Effective Date 1-1-78

Revision: HCFA-PM-87-9 (BERC)
August 1987

State: KANSAS

Citation

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)



- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.



At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.



At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.



Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

TN No. MS-87-36
Supersedes
TN No. MS-84-7

Approval Date 10-24-87

Effective Date 10-1-87

60a

Revision: HCFA-PM-87-9 (BERC)
August 1987

State: KANSAS

Citation 4.19 (d) (Continued)

42 CFR 447.252
through
42 CFR 447.280

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to ICFs, other ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

(4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

TN No. MS-87-36
Supersedes
TN No. MS-84-7

Approval Date 10-24-87

Effective Date 10-1-87

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 447.45 (c)
AT-79-50

4.19 (e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Okay

TN # 79-3
Supersedes

179 does not show pg #, but some topic
Approval Date 12-17-79 Effective Date 10-1-77

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation

42 CFR 447.15

AT-78-90

AT-80-34

48 FR 5730

4.19 (f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TN No. MS-87-22
Supersedes
TN No. MS-83-27

Approval Date Sept 4, 87

Effective Date 4/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation

42 CFR 447.201
42 CFR 447.202
AT-78-90

4.19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

179 does not show this off

TN # 79-3
Supersedes

Approval Date *12-14-79*

Effective Date *10-1-79*

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State KANSAS

Citation

42 CFR 447.201
42 CFR 447.203
AT-78-90

4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

179 does not show this pg

TN # 79-3
Supersedes
TN # _____

Approval Date 12-14-79 Effective Date 10-1-79

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation

42 CFR 447.201
42 CFR 447.204
AT-78-90

4.19 (i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

179 does not show this pg

TN # 79-3
Supersedes

Approval Date 12-14-79

Effective Date 10-1-79

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State: Kansas

Citation

42 CFR 447.201 and 447.205 4.19(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

1903(v) of the Act (k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
Supersedes
TN No. MS-87-36

HCFA ID: 7982E

66(a)

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Kansas

Citation

1903(i)(14)
of the Act

4.19(1)

The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

TN/MS-93-02 Approval Date APR 20 1993 Effective Date JAN 01 1993 Supersedes TN/MS-85-08

66(b)

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1997

State/Territory: Kansas

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines
under the Pediatric Immunization Program

1928(c)(2) (i) A provider may impose a charge for the administration of
a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii)
of the Act.

(ii) The State pays the following rate for the administration of a
vaccine:

\$10.00

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for
Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

- Yes, for physicians' services
- dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

- Not applicable. No direct payments are made to recipients.

TIN # 77-6
Supersedes

Approval Date

Current 179 does not show this section/pt II
1/27/78

Effective Date

1-1-78

Revision: HCFA-AT-81-34 (BPP)

OFFICIALState KansasCitation4.21 Prohibition Against Reassignment of
Provider Claims42 CFR 447.10(c)
AT-78-90
46 FR 42699Payment for Medicaid services
furnished by any provider under this
plan is made only in accordance with
the requirements of 42 CFR 447.10.TN # 82-19
Supersedes
TN # _____Approval Date 2/18/82 Effective Date 1/1/82

Revision: HCFA-PM-91-1
FEBRUARY 1994

State/Territory: Kansas

Citation

4.22 Third Party Liability

42 CFR 433.137

- (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
 - (2) 42 CFR 433.145 through 433.148.
 - (3) 42 CFR 433.151 through 433.154.
 - (4) Sections 1902(a)(25)(H) and (I) of the Act.

1902(a)(25)(H) and (I)
of the Act

42 CFR 433.138(f)

- (b) ATTACHMENT 4.22A--

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii)
and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(4)(i)
and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party database and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i)
through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-94-1
FEBRUARY 1994

State/Territory: Kansas

Citation

4.22 (continued)

42 CFR 433.139(b)(3)
(ii)(A)

(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(c)

(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(c).

42 CFR 433.139(f)(2)

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)

(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

AUG 01 1994

TN#MS-94-13 Approval Date _____ Effective Date 07/01/94 Supersedes TN#MS-90-15

Revision: HCFA-PM-91-1
FEBRUARY 1994

State/Territory: Kansas

Citation 4.22 (continued)

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s)--

Other appropriate agency(s) of another state--

Courts and law enforcement officials.

1902(a)(60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Revision: HCFA-AT-84-2 (BERC)
01-84

State Kansas

Citation
42 CFR Part 434.4
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

TN # MS-84-08
Supersedes
TN # _____

Approval Date 4/25/84 Effective Date 1/1/84

Stata Plan TN# MS84-8 Effective Date Jan/1/84

Supersedes TN# _____ Approval Date 4/25/84

Revision: HCFA-PM-94-2 (BPD)
April 1994

State/Territory: Kansas

Citation
42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
At-80-25
AT-80-34
52 FR 32544
P.L 100-203
(Sec. 4211)
54 FR 5316
56 FR 48826

4.24

Standards for Payments for Nursing Facility
and Intermediate Care Facility for the
Mentally Retarded Services

With respect to nursing facilities and
intermediate care facilities for the
mentally retarded, all applicable requirements
of 42 CFR Part 442, Subparts B and C are met.

_____ Not applicable to intermediate care
facilities for the mentally retarded;
such services are not provided under
this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing
Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN # 77-4
Supersedes
TN #

Approval Date 7-22-74

Effective Date 6-5-74

Revision: HCFA-PM- (MB)

State/Territory: KansasCitation1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(A)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

State/Territory: KansasCitation

1927(g)(1)(D)
 42 CFR 456.703(b)

- D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

Prospective DUR
 Retrospective DUR

1927(g)(2)(A)
 42 CFR 456.705(b)

- E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
 42 CFR 456.705(b),
 (1) - (7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)
 42 CFR 456.705(c)
 and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
 42 CFR 456.709(a)

- F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM- (MB)

State/Territory: KansasCitation1927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

- Directly, or
- X Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- medical quality assurance.

1927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

State/Territory: KansasCitation1927(g)(3)(C)
42 CFR 456.711

G.4 The interventions include in appropriate instances:

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-Face discussions
- intensified monitoring/review of prescribers/dispensers

1927(g)(3)(D)
42 CFR 456.712
(A) and (B)

H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.

1927(h)(1)
42 CFR 456.722

I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- real time eligibility verification
- claims data capture
- adjudication of claims
- assistance to pharmacists, etc. applying for and receiving payment.

1927(g)(2)(A)(i)
42 CFR 456.705(b)

2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

1927(j)(2)
42 CFR 456.703(c)

J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

Revision: HCFA-PM-92-2 (MB)

1992
MARCH

State/Territory: KANSAS

Citation

1927(g)(3)(B)

X

The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacist and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in:

- Clinically appropriate prescribing and dispensing of covered outpatient drugs.
- Monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

1927(g)(3)(C)

X

The activities of the DUR Board include:

- Retrospective DUR
- Application of Standards
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR
- Interventions include in appropriate instances:
 - Information dissemination
 - Written, oral, and electronic reminders
 - Face to Face discussions
 - Intensified monitoring/review of providers/dispensers

1927(g)(3)(D)

X

An annual report is submitted to the Secretary, including a report from its DUR Board, on the DUR program.

TN No. MS-92-12
Supersedes
TN No. Nothing

Approval Date MAY 18 1992 Effective Date MAY 01 1992

Revision: HCFA-AT-80-38 (BPP).
May 22, 1980

State KANSAS

Citation
42 CFR 431.115 (c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider
or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

179 does not show pg# but same topic

TN # 80-9
Supersedes
TN #

Approval Date 9-8-80

Effective Date 7-1-80

KANSAS MEDICAID STATE PLAN

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Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Kansas

Citation

42 CFR 431.152;
AT-79-18
52 FR 22444;
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act; P.L.
100-203 (Sec. 4211(c)).

4.28 Appeals Process

- (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
- (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3
JUNE 1999

State: Kansas

Citation

1902(a)(4)(C) of the
Social Security Act
P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the
Social Security Act
P.L. 105-33
1932(d)(3)
42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

TN # #03-08
Supersedes TN # 01-06

Effective Date August 1, 2003
Approval Date August 28, 2003

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of
Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

The agency, under the authority of State law, imposes broader sanctions.

TN No. MS-87-42
Supersedes
TN No. MS-87-23

Approval Date 12/23/87

Effective Date 10/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation

(b) The Medicaid agency meets the requirements of –

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation—

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

1932(d)(1)
42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) 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. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Kansas

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
- (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

TN No. MS-87-42
Supersedes
TN No. Nothing

Approval Date 12/23/87

Effective Date 10/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967

54FR 8738

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

TN No. MS-87-42
Supersedes
TN No. MS-87-36

Approval Date 12/23/87

Effective Date 10/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Kansas

Citation

1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L. 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN No. MS-87-42
Supersedes
TN No. MS-87-24

Approval Date 12/23/87

Effective Date 10/1/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERG)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Kansas

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

Total waiver

Alternative system

Partial implementation

TN No. MS-88-36
Supersedes
TN No. Nothing

Approval Date

12/21/88

Effective Date

10/1/88

HCFA ID: 1010P/0012P

Revision: HCFA-PM-95-4 (HSQB)
June 1995

State/Territory: Kansas

- Citation 4.35 Enforcement of Compliance for Nursing Facilities
- 42 CFR §488.402(f) (a) Notification of Enforcement Remedies
- When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).
- (i) The notice (except for civil money penalties and State monitoring) specifies the:
- (1) nature of noncompliance,
 - (2) which remedy is imposed,
 - (3) effective date of the remedy, and
 - (4) right to appeal the determination leading to the remedy.
- 42 CFR §488.434 (ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.
- 42 CFR §488.402(f)(2) (iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.
- 42 CFR §488.456(c)(d) (iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.
- 42 CFR §488.488.404(b)(1) (b) Factors to be Considered in Selecting Remedies
- (i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).
- The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
June 1995

State/Territory: Kansas

Citation

(c) Application of Remedies

42 CFR
§488.410

- (i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR
§488.417(b)
§1919(h)(2)(C)
of the Act.

- (ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR
§488.414
§1919(h)(2)(D)
of the Act.

- (iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR
§488.408
§1919(h)(2)(A)
of the Act.

- (iv) The State follows the criteria specified at 42 CFR § 488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR
§488.412(a)

- (v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR
§488.406(b)
§1919(h)(2)(A)
of the Act.

- (i) The State has established the remedies defined in 42 CFR 488.406(b).

- (1) Termination
 (2) Temporary Management
 (3) Denial of Payment for New Admissions
 (4) Civil Money Penalties
 (5) Transfer of Residents; Transfer of Residents with Closure of Facility
 (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
June 1995

State/Territory: Kansas

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) _____ The State uses alternative remedies. The State established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

- _____ (1) Temporary Management
- _____ (2) Denial of Payment for New Admissions
- _____ (3) Civil Money Penalties
- _____ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- _____ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
§1910(h)(2)(F)
of the Act.

(e) _____ State Incentive Programs

- _____ (1) Public Recognition
- _____ (2) Incentive Payments

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Kansas

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)
and 1902(a)(53)
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

SN No. <u>MS-91-41</u>	Approval Date <u>JAN 79</u>	Effective Date <u>OCT 6 1991</u>
Supersedes		
TN No. <u>Nothing</u>		
		HCFA ID: 7982E

KANSAS MEDICAID STATE PLAN

79n

Revision: HCFA-PM-91-10
December 1991

(BPD)

State/Territory: Kansas

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

4.38 Nurse Aide Training and Competency
Evaluation for Nursing Facilities

- (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
- (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
- X (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
- (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
- (e) The State requires a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
- X (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Revision: HCFA-PM-91-10
DECEMBER 1991

790
(BFD)

State/Territory: Kansas

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program. *
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

* during surveys and randomly selected site visits by the program educator and the Kansas Department of Education.

TN No. MS-92-05
Supersedes
TN No. Nothing

Approval Date MAR 27 1992

Effective Date 01/01/92

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM-91-10
December 1991

79p
(BPD)

State/Territory: Kansas

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).
P.L. 105-15(Section 1)

- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
- (n) The state does not grant approval of a nurse aide training and competency evaluation program for a period of longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
- X (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154 unless a waiver has been granted permitting the State to waive the 2 year prohibition of a nurse aide training and competency evaluation program offered in (but not by) certain nursing homes if the State follows the criteria outlined in the NATCEP Waiver Taskforce Report dated July, 1998.
- (r) The State withdraws approval of nurse aide training and competency evaluation programs that do not permit unannounced visits by the State.

JUN 18 1999

Revision: HCFA-PM-91-10
DECEMBER 1991

79g
(BPD)

State/Territory: Kansas

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
- (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
- (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
- (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
- (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
- X (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
- (y) The State has a standard for successful completion of competency evaluation programs.

TN No. MS-92-05
Supersedes
TN No. Nothing

Approval Date MAR 27 1992

Effective Date 01/01/92

KANSAS MEDICAID STATE PLAN

79r

Revision: HCFA-PM-91-10
December 1991

(BPD)

State/Territory: Kansas

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
- X (aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
- (bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
- X (cc) The State includes home health aides on the registry.
- (dd) The State contracts the operation of the registry to a non State entity.
- X (ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
- X (ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

KANSAS MEDICAID STATE PLAN

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Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Kansas

Citation
Secs.

1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual
Resident Review in Nursing Facilities

- (a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).
- (b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.
- (c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.
- (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.
- X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

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79t

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Kansas

4.39 (Continued)

- _____ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.
- (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

State/Territory: Kansas

Citation 4.40 Survey & Certification Process

- Sections 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (sec. 4212(a))
- 1919(g)(1) (B) of the Act
- 1919(g)(1) (C) of the Act
- (a) The state assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
- (b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
- (c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
- (d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?
- (e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
- (f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

State/Territory: Kansas

1919(g)(2)
(A)(i) of
the Act

(g) The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.

1919(g)(2)
(A)(ii) of
the Act

(h) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.

1919(g)(2)
(A)(iii)(I)
of the Act

(i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.

1919(g)(2)
(A)(iii)(II)
of the Act

(j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

1919(g)(2)
(B) of the
Act

(k) The State conducts extended surveys immediately, or if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.

1919(g)(2)
(C) of the
Act

(l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

1919(g)(2)
(D) of the
Act

- (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.

1919(g)(2)
(E)(i) of
the Act

- (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.

1919(g)(2)
(E)(ii) of
the Act

- (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.

1919(g)(2)
(E)(iii) of
the Act

- (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.

1919(g)(4)
of the Act

- (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.

1919(g)(5)
(A) of the
Act

- (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under Section 1126 of the Act.

1919(g)(5)
(B) of the
Act

- (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.

1919(g)(5)
(C) of the
Act

- (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.

1919(g)(5)
(D) of the
Act

- (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92- 2
MARCH 1992

(HSQB)

State/Territory: KANSAS

<u>Citation</u>	<u>4.41 Resident Assessment for Nursing Facilities</u>
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b) The State is using: _____ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the <u>State Operations Manual</u>) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	<u>X</u> a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the <u>State Medicaid Manual for the Secretary's approval criteria</u>) [§1919(e)(5)(B)].

TN No. MS-92-12

Supersedes

TN No. Nothing

Approval Date MAY 18 1992

Effective Date MAY 01 1992

HCFA ID: MAY 01 1992

KANSAS MEDICAID STATE PLAN

State of Kansas
Department of Social and
Rehabilitation Services

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
Background Information at Intake/Admission

State of Kansas
Department of Health
and Environment

FACILITY _____

I. IDENTIFICATION INFORMATION

1. RESIDENT NAME	First _____ (M.I.) Last _____	
2. DATE OF CURRENT ADMISSION	Month _____ Day _____ Year _____	
3. MEDICARE NO. (SS# or Comparable No. if no Medicare No.)	_____	
4. FACILITY PROVIDER NO.	Federal No. _____	
5. GENDER	1. Male 2. Female	
6. RACE/ETHNICITY	1. American Indian/Alaskan Native 4. Hispanic 2. Asian/Pacific Islander 5. White, not of hispanic origin 3. Black, not of Hispanic origin	
7. BIRTHDATE	Month _____ Day _____ Year _____	
8. LIFETIME OCCUPATION	_____	
9. PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes _____ (Specify)	
10. RESIDENTIAL HISTORY PAST 5 YEARS	(Check all settings resident lived in during last 5 years prior to admission) Prior stay at this nursing facility a. Other nursing facility/residential facility b. MH/psychiatric setting c. MR/DD Setting d. NONE OF ABOVE e.	
11. MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1. Yes	
12. CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD Status, that were manifested before age 22, and are likely to continue indefinitely.) Not Applicable - no MR/DD (Skip to Item 13) a. MR/DD with Organic Condition b. Cerebral palsy c. Down's syndrome d. Autism e. Epilepsy f. Other organic condition related to MR/DD g. MR/DD with no organic condition h. Unknown	
13. MARITAL STATUS	1. Never Married 4. Separated 2. Married 5. Divorced 3. Widowed	
14. ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing facility 4. Other	
15. LIVED ALONE	0. No 1. Yes 2. In other facility	
16. ADMISSION INFORMATION AMENDED	(Check all that apply) Accurate information unavailable earlier a. Observation revealed additional information b. Resident unstable at admission c.	

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1. DATE OF CURRENT READMISSION	Month _____ Day _____ Year _____
2. MARITAL STATUS	1. Never Married 4. Separated 2. Married 5. Divorced 3. Widowed
3. ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing facility 4. Other
4. LIVED ALONE	0. No 1. Yes 2. In other facility

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

CUSTOMARY ROUTINE (Year prior to first admission to a nursing facility)	(Check all that apply. If all items are UNKNOWN, check box "y")
1. CYCLE OF DAILY EVENTS	
Stays up late at night (e.g., after 9 pm)	a.
Naps regularly during day (at least 1 hour)	b.
Goes out 1+ days a week	c.
Stays busy with hobbies, reading, or fixed daily routine	d.
Spends most time alone or watching TV	e.
Moves independently indoors (with appliances, if used)	f.
Use of tobacco products at least daily	g.
NONE OF ABOVE	h.
2. EATING PATTERNS	
Distinct food preferences	i.
Eats between meals all or most days	j.
Use of alcoholic beverage(s) at least weekly	k.
NONE OF ABOVE	l.
3. HYGIENE PATTERNS	
In bedclothes much of day	m.
Wakens to toilet all or most nights	n.
Has irregular bowel movement pattern	o.
Prefers showers for bathing	p.
Prefers bathing in PM	q.
NONE OF ABOVE	r.
4. INVOLVEMENT PATTERNS	
Daily contact with relatives/close friends	s.
Usually attends church, temple, synagogue, (etc.)	t.
Finds strength in faith	u.
Daily animal companion/presence	v.
Involved in group activities	w.
NONE OF ABOVE	x.
5. UNKNOWN - Resident/family unable to provide information	y.

Signature of RN Assessment Coordinator: _____

Date: _____

Signatures of Others Who Completed Part of the Assessment: _____

END

State of Kansas
Department of Social and
Rehabilitation Services

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

State of Kansas
Department of Health
and Environment

MS-2101
10-91

FACILITY _____

Assessment Date - -
Month Day Year

Original (O) or Correction (#)

Signature of
RN Assessment Coordinator _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME	First _____ (M.I.) Last _____
2. SOCIAL SECURITY NO.	<input type="text"/>
3. MEDICAID NO. (if applicable)	<input type="text"/>
4. MEDICAL RECORD NO.	<input type="text"/>
5. REASON FOR ASSESSMENT	1. Initial admission assessment 2. Hosp./Medicare reassessment 3. Readmission, not Medicare 4. Annual assessment 5. Significant change in status (e.g., UR) 6. Quarterly 7. Other
6. CURRENT PAYMENT SOURCE(S) FOR STAY	(Billing Office to code payment sources) 0. Not Used 1. Per Diem 2. Ancillary 3. Both Medicaid Medicare CHAMPUS VA Self pay/Private insur. Other
7. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) Legal guardian Other legal oversight Durable power attmy./health care proxy a. Family member responsible b. Resident responsible c. NONE OF ABOVE d. e. f.
8. ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Organ donation Autopsy request a. Feeding restrictions b. Medication restrictions c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. NONE OF ABOVE
9. DISCHARGE PLANNED WITHIN 3 MOS.	(Does not include discharge due to death) 0. No 1. Yes 2. Unknown/uncertain
10. MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

SECTION B. COGNITIVE PATTERNS

1. COMATOSE	(Persistent vegetative state/no discernable consciousness) 0. No 1. Yes (Skip to SECTION H.)
2. MEMORY	(Recall of what was learned or known) a. Short-term memory OK - seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK - seems/appears to recall long past 0. Memory OK 1. Memory problem

3. MEMORY/RECALL ABILITY	(Check all that the resident is normally able to recall during last 7 days) Current season Location of own rm. Staff names/faces a. That he/she is in b. a nursing facility c. NONE OF ABOVE d. e.
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING	Made decisions regarding tasks of daily life 0. Independent - decisions consistent/reasonable 1. Modified independence - some difficulty in new situations only 2. Moderately impaired - decisions poor; cues/supervision required 3. Severely impaired - never/rarely made decisions
5. INDICATORS OF DELIRIUM - PERIODIC DISORDERED THINKING/AWARENESS	(Check if condition over last 7 days appears different from usual functioning) Less alert, easily distracted Changing awareness of environment Episodes of incoherent speech Periods of motor restlessness or lethargy Cognitive ability varies over course of day NONE OF ABOVE a. b. c. d. e. f.
6. CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities - in last 90 days 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING	(With hearing appliance, if used) 0. Hears adequately - normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situation only - speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used Hearing aid, present and not used Other receptive comm. technique used (e.g. lip read) NONE OF ABOVE a. b. c. d.
3. MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech Writing messages to express or clarify needs Signs/gestures/sounds. a. Communication board b. American Sign Language or Braille c. Other d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. NONE OF ABOVE
4. MAKING SELF UNDERSTOOD	(Expressing information context - however able) 0. Understood 1. Usually understood - difficulty finding words or finishing thoughts 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/Never understood
5. SPEECH CLARITY	Speech unclear 0. No 1. Yes

EXAMPLE:
Code the appropriate response =
Check all the responses that apply = a.

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

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10-91

Resident: _____

SS#: _____

Facility #: _____

SECTION C. CONT.

6. ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content - however able) 0. Understands 1. Usually understands - may miss some part/ intent of message 2. Sometimes understands - responds adequately to simple, direct communication 3. Rarely/never understands	
7. CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand or hear information has changed over last 90 days 0. No change 1. Improved 2. Deteriorated	

SECTION D. VISION PATTERNS

1. VISION	(Ability to see in adequate light and with glasses if used) 0. Adequate- sees fine detail, including regular print in newspapers/books 1. Impaired - sees large print, but not regular print in newspapers/books 2. Highly impaired - limited vision, not able to see newspaper headlines, appears to follow objects with eyes 3. Severely impaired - no vision or appears to see only light, color, or shapes	
2. VISUAL LIMITATIONS/DIFFICULTIES	Side vision problems - decreased peripheral vision: (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights, sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	a. b. c.
3. VISUAL APPLIANCES	Glasses; contact lenses; lens implant; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. SAD OR ANXIOUS MOOD	(Check all that apply during last 30 days) VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief) DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS Tearfulness, emotional groaning, sighing, breathlessness Motor agitation such as pacing, handwringing or picking Pervasive concern with health Recurrent thoughts of death - e.g., believes he/she about to die, have a heart attack Suicidal thoughts/actions Failure to eat or take medications Withdrawal from self-care, leisure activities Reduced communications Early morning awakening with unpleasant mood NONE OF ABOVE	a. b. c. d. e. f. g. h. i. j. k.
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2. MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days - not easily altered, doesn't "cheer up" 0. No 1. Yes	
3. PROBLEM BEHAVIOR	(Code for behavior in last 7 days) 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently a. WANDERING (moved with no rational purpose; seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/throw food/feces, hoarding, rummaged through others' belongings)	
4. RESIDENT RESISTS CARE	(Check all types of resistance that occurred in the last 7 days) Resisted taking medications/injection Resisted ADL assistance Resisted eating NONE OF ABOVE	a. b. c. d.
5. BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints and/or psychotropic medications in this category.) 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6. CHANGE IN MOOD	Change in mood in last 90 days 0. No change 1. Improved 2. Deteriorated	
7. CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days 0. No change 1. Improved 2. Deteriorated	

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

MS-2101
10-81

Resident: _____ SS#: _____ Facility #: _____

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		Adjusts easily to changes in routine	g.
		NONE OF ABOVE	h.
2.	UNSETTLED RELATIONSHIPS	Cover/over conflict with and/or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family or friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Avoids interactions with others	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		NONE OF ABOVE	c.

SECTION G. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days)	
		Resident awake all or most of time (i.e., no naps or naps no more than one hour per time period) in the:	
		Morning <input type="checkbox"/> a.	Evening <input type="checkbox"/> c.
		Afternoon <input type="checkbox"/> b.	NONE OF ABOVE <input type="checkbox"/> d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most more than 2/3 of time	2. Little less than 1/3 of time
		1. Some 1/3 to 2/3 of time	3. None
		(Check all settings in which activities are preferred)	
		Own room <input type="checkbox"/> a.	Outside facility <input type="checkbox"/> d.
3.	PREFERRED ACTIVITY SETTINGS	Day/activity room <input type="checkbox"/> b.	NONE OF ABOVE <input type="checkbox"/> e.
		Inside NF/off unit <input type="checkbox"/> c.	
		(Check all activities preferences whether or not activity is currently available to resident)	
		Cards/other games <input type="checkbox"/> a.	Going outdoors (walking/wheeling/sitting) <input type="checkbox"/> h.
4.	GENERAL ACTIVITY PREFERENCES (Adapted to resident's current abilities)	Crafts/arts <input type="checkbox"/> b.	Watch TV <input type="checkbox"/> i.
		Exercise/sports <input type="checkbox"/> c.	Gardening/plants <input type="checkbox"/> j.
		Music <input type="checkbox"/> d.	Talking/conversing <input type="checkbox"/> k.
		Read/write <input type="checkbox"/> e.	Helping others <input type="checkbox"/> l.
		Spiritual/religious activities <input type="checkbox"/> f.	NONE OF ABOVE <input type="checkbox"/> m.
		Trips/shopping <input type="checkbox"/> g.	

5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses or indicates preferences for other activities or choices.
		0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/>
6.	ISOLATION ORDERS	Resident is under medical orders for isolation which prohibits participation in group activities.
		0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/>

SECTION H. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1.	ADL SELF-PERFORMANCE (Code for resident's PERFORMANCE over all shifts during last 7 days - Not including setup)	0. INDEPENDENT - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days.		
		1. SUPERVISION - Oversight, encouragement, or cueing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days		
		2. LIMITED ASSISTANCE - Resident highly involved in activity, received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3+ times - OR - More help provided only 1 or 2 times during last 7 days.		
		3. EXTENSIVE ASSISTANCE - While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times: - Weight-bearing support - Full staff performance during part (but not all) of last 7 days		
2.	ADL SUPPORT PROVIDED (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff		
		1. Setup help only		
		2. One-person physical assist		
		3. Two + persons physical assist		
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	LOCO-MOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

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10-91

Resident _____ SS#: _____ Facility #: _____

SECTION H. CONT.

3.	BATHING	a. How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below. Use support codes on preceding page. 0. Independent - No help provided 1. Supervision - Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence	1 2 S P S
		b. Tub/whirlpool bath Shower	a. b.
		Bed bath Bath lift NONE OF ABOVE	c. d. e.
4.	BODY CONTROL PROBLEMS	(Check all that apply during last 7 days) Balance - partial or total loss of ability to balance self while standing Bedfast all or most of the time Hemiplegia/hemiparesis Quadriplegia Arm - partial or total loss of voluntary movement	a. b. c. d. e.
		Hand - lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) Leg - partial or total loss of voluntary movement Leg - unsteady gait Trunk - partial or total loss of ability to position balance, or turn body Amputation NONE OF ABOVE	f. g. h. i. j. k.
5.	CONTRACTURES	(Check all that apply in the prior 7 days) Contractures - None Contractures - Face/Neck Contractures - Shoulder/Elbow Contractures - Hand/Wrist Contractures - Hip/Knee Contractures - Foot/Ankle	a. b. c. d. e. f.
6.	MOBILITY APPLIANCES/DEVICES	(Check all that apply during last 7 days) Cane/Walker Brace/Prosthesis Wheeled self Other person wheeled	a. b. c. d.
		Lifted (manually/mechanically) Transfer aid (slide brd) Trapeze NONE OF ABOVE	e. f. g. h.
7.	TASK SEGMENTATION	Resident requires that some or all of ADL activities be broken into a series of sub-tasks so that resident can perform them. 0. No. 1. Yes	
8.	CHANGE IN ADL FUNCTION	Change in ADL function in last 90 days 0. No change 1. Improved 2. Deteriorated	

9.	ADL FUNCTIONAL REHAB. POTENTIAL	Resident believes he/she capable of increased independence in at least some ADLs Direct care staff believe resident capable of increased independence in at least some ADLs Resident able to perform tasks/activity but is very slow Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) Self-performance restricted due to absence of assistive devices (e.g., brace or wheelchair) Tires noticeably during most days Active avoidance of activity for which resident is physically/cognitively capable (e.g., fear of falling) NONE OF ABOVE	a. b. c. d. e. f. g. h.
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SECTION I. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident performance over all shifts.)	0. CONTINENT - Complete control 1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. INCONTINENT - Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed
2.	INCONTINENCE RELATED TESTING	(Skip if resident's bladder and bowel continence codes equals 0/1 and no catheter used) Resident has been tested for a urinary tract infection Resident has been checked for presence of a fecal impaction There is adequate bowel elimination NONE OF ABOVE
3.	APPLIANCES AND PROGRAMS	Any scheduled toiletting plan External (condom) catheter Indwelling catheter Intermittent catheter
		Did not use toilet rny/commode/urinal Pads/briefs used Enemas/irrigation Ostomy NONE OF ABOVE
4.	CHANGE IN URINARY CONTINENCE	Change in urinary continence, appliances, and/or programs in last 90 days 0. No change 1. Improved 2. Deteriorated

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

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Resident: _____

SS#: _____ Facility #: _____

SECTION J. SKIN CONDITION AND FOOT CARE

1.	STASIS ULCER	Open lesion caused by poor venous circulation to lower extremities 0. No 1. Yes	
2.	PRESSURE ULCERS	(Record the number of sites for presence of each stage of pressure ulcers. If none are present at the stage stated, record "0" (zero) in the space provided. Code all that apply to resident during last 7 days.) a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.	No. at Stage
3.	HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days. 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	Skin desensitized to pain, pressure, discomfort Abrasions, bruises Burns (second or third degree) Surgical wounds Cuts (other than surgery) Open lesions other than stasis/pressure ulcers, or cuts Rashes NONE OF ABOVE	a. b. c. d. e. f. g. h.
5.	ACTIVE SKIN CARE PROGRAM	Protective/preventive skin care Turning/repositioning program Pressure relieving beds, bed/chair pads (e.g., egg crate pads) Surgical wound or pressure ulcer care Other skin care/treatment Special nutrition/hydration program Special application/ointments/medications Ostomy care (e.g., trach) (routine/stable) NONE OF ABOVE	a. b. c. d. e. f. g. h. i.
6.	SPECIAL STOCKINGS	During the past 7 days has the resident used TED or similar stockings? 0. No 1. Yes	
7.	FOOT CARE	(Check all that apply to resident during LAST 30 DAYS) Protective/preventive Foot Care: (e.g., special shoes, inserts, pads, toe separators, nail/callus trimming, etc.) Active Foot Care Treatments: Foot Soaks Dressing with and without topical medications, etc. NONE OF ABOVE	a. b. c. d.

SECTION K. DISEASE DIAGNOSES/CONDITIONS

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.)

1.	DISEASES	(If none apply, check the NONE OF ABOVE box)	
	HEART/CIRCULATION	Arterioclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Hypertension Hypotension Peripheral vascular disease Other cardiovascular disease	a. b. c. d. e. f. g.
	NEUROLOGICAL	Alzheimer's Dementia other than Alzheimer's Aphasia Cerebrovascular accident (stroke) Multiple Sclerosis Parkinson's disease	h. i. j. k. l. m.
	PULMONARY	Emphysema/ Asthma/COPD Pneumonia	n. o.
	PSYCHIATRIC/MOOD	Anxiety disorder Depression Manic depressive (bipolar disease)	p. q. r.
	SENSORY	Cataracts Glaucoma	s. t.
	OTHER	Allergies Anemia Arthritis Cancer Diabetes mellitus Explicit terminal prognosis Hypothyroidism Osteoporosis Seizure disorder Septicemia Urinary tract infection in last 30 days NONE OF ABOVE	u. v. w. x. y. z. aa. bb. cc. dd. ee. ff.
2.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES		a. b. c. d. e. f.
3.	PROBLEMS CONDITIONS AND SIGNS/ SYMPTOMS	(Check all problems that apply; last 7 days, UNLESS OTHER TIME FRAME STATED) Constipation Diarrhea Dizziness / vertigo Fecal impaction Fever Hallucinations /delusions Internal bleeding Joint pain Pain - Res. complains or shows evidence of pain daily or almost daily	a. b. c. d. e. f. g. h. i.
		Recurrent lung aspirations in last 90 days Shortness of breath (Dyspnea) Syncope (fainting) Vomiting Respiratory infection Chest Pain NONE OF ABOVE	j. k. l. m. n. o. p.
4.	EDEMA	(Check all that apply in the last 7 days) Edema - none Edema - generalized Edema - localized not pitting Edema - pitting Edema - other	a. b. c. d. e.

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

Resident: _____

SS#: _____ Facility #: _____

SECTION K. CONT.

5. ACCIDENTS	(Check all that apply)		Other fractures in last 180 days NONE OF ABOVE	d. e.
	Fell - past 30 days	a.		
	Fell - past 31-180 days	b.		
6. STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating.		NONE OF ABOVE	a. b. c.
	Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem.			
	NONE OF ABOVE			

SECTION M. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	Has dentures and/or removable bridge	b.
	Some/all natural teeth lost - does not have or does not use dentures (or partial plates)	c.
	Broken, loose, or carious teeth	d.
	Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers, or rashes	e.
	Daily cleaning of teeth/dentures	f.
	NONE OF ABOVE	g.

SECTION L. ORAL/NUTRITION STATUS

1. ORAL PROBLEMS	a. Chewing problem	a.	
	b. Swallowing problem	b.	
	c. Mouth pain	c.	
	d. NONE OF ABOVE	d.	
2. HEIGHT AND WEIGHT	a. Record height in inches	HT (in.)	
	b. Record weight in pounds	WT (lb.)	
	Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice - e.g., in a.m. after voiding before meal, with shoes off, and in nightclothes.		
3. NUTRITIONAL PROBLEMS	Complains about the taste of many foods		a.
	Insufficient fluid; dehydrated	b.	
	Did NOT consume all/almost all liquids provided during last 3 days	c.	
4. NUTRITIONAL APPROACH	Parenteral/IV	a.	
	Feeding tube	b.	
	Mechanically altered diet	c.	
	Syringe (oral feeding)	d.	
Therapeutic diet		e.	
Diet supplement between meals		f.	
Plate guard, stabilized built-up utensil, etc.		g.	
NONE OF ABOVE		h.	

SECTION N. SPECIAL TREATMENTS, DEVICES, PROC., & SUPPLIES

1. SPECIAL TREATMENTS AND PROCEDURES	2. SPECIAL CARE - (Check treatments received during the last 14 days.)		g. h. i. j. k. l.
	Chemotherapy	a.	
	Radiation	b.	
	Dialysis	c.	
	Suctioning	d.	
	Trach care	e.	
	IV meds.	f.	
	Transfusions	g.	
	O2	h.	
	Intake/Output	i.	
Ventilator/Respirator	j.		
Other	k.		
NONE OF ABOVE		l.	
b. THERAPIES - Record the number of days and total minutes each of these therapies was administered (for at least 10 minutes) in the last 7 days (0 if none)			
Box A = # of days administered for 10 mins. or more		A	
Box B = Total # of minutes administered in last 7 days		B	
a. Speech - language pathology and audiology services			
b. Occupational therapy			
c. Physical therapy			
d. Psychological therapy (any licensed prof.)			
e. Respiratory therapy			
f. Recreation therapy			
2. REHABILITATION/RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation/restorative technique/practice was provided for more than or equal to 15 minutes per day, to the resident in the last 7 days. (Enter 0 if none)		
	a. Range of Motion (passive)		
	b. Range of Motion (active)		
	c. Splint/Brace Assistance		
	d. Reality Orientation		
	e. Remotivation		
	Training and Skill Practice in:		
	f. Locomotion/Mobility		
	g. Dressing/Grooming		
	h. Eating/Swallowing		
i. Transfer			
j. Amputation Care			
3. DEVICES AND RESTRAINTS	Use the following code for last 7 days:		
	0. Not used		
	1. Used less than daily		
	2. Used daily		
	a. Bed rails		
b. Trunk restraint			
c. Limb restraint			
d. Chair prevents rising			

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

MS-2101
10-91

Resident _____ SS#: _____ Facility #: _____

SECTION N. CONT.

4.	SUPPLIES	Record the number of units of the supply listed that have been used or consumed by the resident in the past 7 days. (Enter 0 if none)	
		a. Sterile Dressings	
		b. Unique/Special Decubitus Care Supplies	
		c. Peritoneal Dialysis Supplies	
5.	PHYSICIAN ORDERS	IN THE LAST 30 DAY PERIOD since the resident was admitted, how many times has the physician (authorized assistant/practitioner) changed the resident's orders? (Do not include order renewals without change.)	
6.	NO LAB TEST	Check if no laboratory tests performed in the last 90 days. (Skip to Section O)	
7.	LABORATORY TEST	How many lab samples (blood/urine/etc.) have been collected IN THE PAST 30 DAYS?	
8.	ABNORMAL LAB RESULTS	a. How many laboratory tests were returned with abnormal values during the past 90 days? b. How many abnormal values resulted in treatment or care planning in the past 30 days?	

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	Record the number of different medications used in the last 7 days. (Enter "0" if none used. Skip to item 5.)	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days. 0. No 1. Yes	
3.	INJECTIONS	Record the number of days injections of any type received during the last 7 days.	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	Record the NUMBER OF DAYS during the last 7 days; enter "0" if not used; enter "1" if long acting med. used less than weekly a. Antipsychotics b. Antianxiety/hypnotics c. Antidepressants	
5.	PREVIOUS MEDICATION RESULTS	Skip this question if resident currently receiving antipsychotics, antidepressants, or anti-anxiety/hypnotics - otherwise code correct response for last 90 days Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences.) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. PARTICIPATION IN ASSESSMENT

1.	PARTICIPATE IN ASSESSMENT	Resident: 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/>	Family: 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No Family	Significant Other: 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. None
----	---------------------------	--	--	--

P.2. SIGNATURES OF THOSE COMPLETING THE ASSESSMENT:

a. Name of RN assessment coordinator _____ b. End Date _____

c. _____

d. Signature _____ Title _____ Sections _____ Date _____

e. _____

f. _____

g. _____

h. _____

P.3.

CASE MIX GROUP	
Medicare <input type="checkbox"/>	State <input type="checkbox"/>

Page 7 of 9

MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last 7 days, unless other time frame indicated)

MS-2101
10-91

Resident: _____ SS#: _____ Facility #: _____

MINIMUM DATA SET - PLUS (MDS+)

SECTION Q: MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen

1. List the medication name and the dosage.

2. RA (Route of Administration). Use the appropriate code from the following list:

- | | |
|-------------------------|------------------|
| 1 = by mouth (PO) | 6 = rectally |
| 2 = sublingual (SL) | 7 = topical |
| 3 = intramuscular (IM) | 8 = inhalation |
| 4 = intravenous (IV) | 9 = enteral tube |
| 5 = subcutaneous (SubQ) | 10 = other |

3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the medication was given.

- | | | |
|---|--------------------------------|----------------|
| PR = (PRN) as necessary | 4D = (QID) four times daily | C = continuous |
| 1H = (qh) every hour | 5D = five times daily | |
| 2H = (q2h) every two hours | 1W = (QWeek) once every week | |
| 3H = (q3h) every three hours | 2W = twice every week | |
| 4H = (q4h) every four hours | 3W = three times every week | |
| 6H = (q6h) every six hours | QO = every other day | |
| 8H = (q8h) every eight hours | 4W = four times every week | |
| 1D = (qd or hs) once daily | 5W = five times every week | |
| 2D = (BID) two times daily
(includes every 12 hours) | 6W = six times every week | |
| 3D = (TID) three times daily | 1M = (QMonth) once every month | |
| | 2M = twice every month | |

4. PRN--n (prn-- number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

5. DRUG CODE: Enter the eleven digits of the National Drug Code (NDC). NOTE: If using the NDC's in the Manual Appendix, the last two digits of the 11 digit NDC define package size have been omitted from the codes listed in the Manual Appendix. If using the Appendix, the NDC should be entered left-justified (the first digit of the code should be entered in the space farthest to the left of the NDC code column.) This should result in the last two spaces being left blank.

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	NDC Codes
EXAMPLE: Coumadin 2.5mg	1	1W		
Digoxin 0.125 mg	1	1D		
Humulin R 25 Units	5	1D	2	
Robitussin 15cc	1	PR		

-92-12 Approval Date MAY 18 1992 Effective Date MAY 01 1992 Supersedes TN# _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Citation
1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas4.42 Employee Education About False Claims Recoveries
(continued)

claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas4.42 Employee Education About False Claims Recoveries
(continued)

and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

SECTION 5 PERSONNEL ADMINISTRATION

Citation

42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

- (a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

179 does not show pg #, similar topic

TN # 77-5

Supersedes

TN #

Approval Date 11-11-77 Effective Date 10-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

5.2 [Reserved]

TN # 77-5
Supersedes
TN #

Approval Date 11/22/77

Effective Date 10/1/77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR Part 432,
Subpart B
AT-78-90

5.3 Training Programs; Subprofessional and
Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

179 does not show pg#, same topic

TN # 78-1
Supersedes
TN # _____

Approval Date 5/24/78 Effective Date 1-1-78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

TN # 77-4

Supersedes

TN # MS-77-4

Approval Date 8-19-77

Effective Date 7-1-77

Revision: HCFA-AT-81- (BPP)

State _____

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 82-27
Supersedes
TN # _____

Approval Date
12-22-82

Effective Date, 5-24-82

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State KANSAS

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

State funds are used to pay all of the non-Federal share of total expenditures under the plan.

There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

TN # 77-4
Supersedes
TN # 115-77-4

Approval Date 8-19-77

Effective Date 7A-77

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No. 0938-

State/Territory: Kansas

SECTION 7 - GENERAL PROVISIONS

Citation 7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN No. <u>MS-91-41</u>	Approval Date <u>JAN 27 1992</u>	Effective Date <u>OCT 01 1991</u>
Supersedes		
TN No. <u>No Number</u>		

HCFA ID: 7982E

51

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No. 0938-

State/Territory: Kansas

Citation 7.2 Nondiscrimination

45 CFR Parts
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

TN No. MS-91-41 Approval Date JAN 21 1991 Effective Date OCT 1 1991
Supersedes _____
TN No. No Number

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No. 0938-

State/Territory: Kansas

Citation 7.3 Maintenance of AFDC Efforts

1902(c) of
the Act

The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
Supersedes
TN No. MS-91-04 HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No. 0938-

State/Territory: Kansas

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid agency will provide opportunity for the Office of the Governor to review State Plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

- Not applicable. The Governor--
 - Does not wish to review any plan material.
 - Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

the Kansas Department of Social and Rehabilitation Services
(Designated Single State Agency)

Date: 10-29-95

Roahille Chomister
(Signature)

Secretary of SRS
(Title)

Janet Setalany
(Signature)

Deputy Secretary of SRS
(Title)

SEP 05 1995

cancelled (voided) checks under titles I, IV-A, X, XIV, and XVI (AABD).

(b) *Definitions.* As used in this section—"Check" means a check or warrant that the State or local agency uses to make a payment.

"Cancelled (voided) check" means a check issued by the State agency or local agency which prior to its being cashed is cancelled (voided) by State or local agency action, thus preventing disbursement of funds.

"Uncashed check" means a check issued by the State agency or local agency which has not been cashed by the payee.

(c) *Refund of Federal financial participation (FFP) for uncashed checks—*
(1) *General provisions.* If a check remains uncashed beyond a period of 180 days from the date it was issued, i.e., the date of the check, it will no longer be regarded as an amount expended because no funds have actually been disbursed. If the State agency has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received.

(2) *Report of refund.* At the end of each calendar quarter, the State agency must identify those checks which remain uncashed beyond a period of 180 days after issuance. The State agency must report on the Quarterly Statement of Expenditures for that quarter all FFP that it received for uncashed checks. Once reported on the Quarterly Statement of Expenditures for a quarter, an uncashed check is not to be reported on a subsequent Quarterly Statement of Expenditures. If an uncashed check is cashed after the refund is made, the State agency may submit a new claim for FFP.

(d) *Refund of FFP for cancelled (voided) checks—*(1) *General provisions.* If the State agency has claimed and received FFP for the amount of a cancelled (voided) check, it must refund the amount of FFP received.
(2) *Report of refund.* At the end of each calendar quarter, the State agency must identify those checks which were cancelled (voided). The State agency must report on the Quarterly Statement of Expenditures for that quarter all FFP received by the State agency for these checks. Once reported on the Quarterly Statement

45 CFR Ch. II (10-1-85 Edition)

of Expenditures for a quarter, a cancelled (voided) check is not to be reported on a subsequent Quarterly Statement of Expenditures.
(50 FR 37661, Sept. 17, 1985)

PART 204—GENERAL ADMINISTRATION—SOCIAL AND REHABILITATION SERVICE GRANT PROGRAMS

Sec.

204.1 Submittal of State plans for Governor's review.

204.2 State plans—format.

204.4 Grant appeals.

§ 204.1 Submittal of State plans for Governor's review.

A State plan under title I, IV-A, IV-B, VI, X, XIV, XVI, or XIX of the Social Security Act, section 101 of the Rehabilitation Act of 1973, or title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act, must be submitted to the State Governor for his review and comments, and the Governor will must provide that the Governor will be given opportunity to review State plan amendments and long-range program planning projections or other periodic reports thereon. This requirement does not apply to periodic statistical or budget and other fiscal reports. Under this requirement, the Office of the Governor will be afforded a specified period in which to review the material. Any comments made will be transmitted to the Social and Rehabilitation Service with the documents.

(Sec. 1102, 49 Stat. 647 (42 U.S.C. 1302))

[39 FR 34542, Sept. 26, 1974]

§ 204.2 State plans—format.

State plans for Federally-assisted programs for which the Social and Rehabilitation Service has responsibility must be submitted to the Service in the format and containing the information prescribed by the Service, and within time limits set in implementing instructions issued by the Service. Such time limits will be adequate for proper preparation of plans and submittal in accordance with the requirements for State Governors' review (see § 204.1 of this chapter).

Office of Family Assistance, HHS

(Sec. 1102, 49 Stat. 647, 42 U.S.C. 1302; sec. 7(b), 68 Stat. 658, 29 U.S.C. 37(b); sec. 139, 84 Stat. 1323, 42 U.S.C. 2677(b))
138 FR 10872, June 27, 1973]

§ 204.4 Grant appeals.

(a) *Scope.* This section applies to certain determinations (as set forth in § 16.5(a) (1) through (4) of this title), made after the effective date of this section, with respect to direct, discretionary project grants awarded by the Social and Rehabilitation Service, and such other grants or grant programs as the Administrator, with the approval of the Secretary, may designate. The statutory authority for current grant programs to which this section applies appears in the appendix to this section. This section is also applicable to determinations with respect to grants which were made under authority which has expired or been repealed since the grants were made, even though such authority does not appear in the appendix.

(b) *Submission.* (1) A grantee who has received notification, as described in § 16.5(b) of this title, of a determination described in § 16.5(a) (1) through (4) of this title, may request reconsideration by informing the Grants Appeals Officer as identified in the final adverse determination or otherwise designated by the Administrator, Social and Rehabilitation Service, Washington, DC 20201 of the grantee's intent to contest the determination. The grantee may request reconsideration. The grantee's request for reconsideration must be postmarked no later than 30 days after the postmark date of the written notification of such determination, except when:

(i) The Grant Appeals Officer grants an extension of time for good cause; or
(ii) The constituent agency fails to make a written notification under the circumstances described in the last sentence of § 16.5(b) of this title, in which case, subject to paragraph (b)(1)(i) of this section, the grantee's request for reconsideration must be postmarked no later than 90 days after the postmark date of the grantee's request for permission to incur an expenditure.

(2) Although the request need not follow any prescribed form, it shall

clearly identify the question or questions in dispute and contain a full statement of the grantee's position with respect to such question or questions, and the pertinent facts and reasons in support of such position. Except in the case of a determination described in the last sentence of § 16.5(b) of this title, the grantee shall attach to his submission a copy of the agency notification described in § 16.5(b)(1) of this title.

(c) *Action by the Service on requests for reconsideration.* (1) Upon receipt of such an application the Grant Appeals Officer will inform the grantee that:

(i) His request is under review, and
(ii) If no decision is received within 90 days (or 45 days in the case of a determination described in the last sentence of § 16.5(b) of this title) of the postmark date of the grantee's request for reconsideration, the determination may be appealed to the Departmental Grant Appeals Board.

(2) The Grant Appeals Officer will reconsider the determination appealed from, considering any material submitted by the grantee and any other material necessary.

(3) If the response to the grantee is adverse to the grantee's position, the response will include notification of the grantee's right to appeal to the Departmental Grant Appeals Board.

APPENDIX

This section is issued under sections 1, 5, 6, and 7 of Reorganization Plan No. 1 of 1953, 18 FR 2053, 67 Stat. 631 and is applicable to programs carried out under the following authorities:

(1) Section 222(a) and (b) of the Social Security Amendments of 1972 (Pub. L. 92-603),
(2) Section 426 of the Social Security Act (42 U.S.C. 262),
(3) Section 707 of the Social Security Act (42 U.S.C. 907),
(4) Section 1110 of the Social Security Act (42 U.S.C. 1310),
(5) Section 1115 of the Social Security Act (42 U.S.C. 1315).

(Secs. 1, 5, 6, 7 Reorganization Plan No. 1 of 1953, 67 Stat. 631)
140 FR 51443, Nov. 5, 1975]

ATTACHMENT 1.1-A
Attorney General's Certification

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM

Attachment 1.1-A

State of Kansas

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

Kansas Health Policy Authority is the

single state agency responsible for:

X administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is:

K.S.A. 2005 Supp. 75-7401 thru 75-7405 and Section 42 of Kansas House Substitute for Senate Bill 272, 2005 Session
(statutory citation)

_____ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

(statutory citation)

4-17-06
DATE

Phill Kline by Asst. Atty. General Mary Feighany
Signature

Attorney General, State of Kansas
Title

TN # #06-04 Approval Date MAY 31 2006 Effective Date 07/01/06 Supersedes #TN #05-04

ATTACHMENT 1.1-B

Waivers under the Intergovernmental Cooperation Act

77-4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Attachment 1.1-B

Page 1

State of Kansas

WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED
UNDER THE INTERGOVERNMENTAL COOPERATION ACT OF 1968

Waiver #1. ^{1/}

a. Waiver was granted on _____
(date)

b. The organizational arrangement authorized, the nature
and extent of responsibility for program administration
delegated to _____,
(name of agency)

the resources and/or services of such agency to be utilized
in administration of the plan are described below:

NOT APPLICABLE

77-4

St. Kan Tr. 6/24/77 Insp. 8/19/77 Effective 2/1/77

^{1/} (Information on any additional waivers which have been granted
is contained in attached sheets.)

- c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

St. Kan. Incorp. 2/29/74 Effective 6/5/74

20179

ATTACHMENT 1.2-A

Organization and Function of State Agency



ROBERT M. DAY, Ph.D., DIRECTOR

K A N S A S

KATHLEEN SEBELIUS, GOVERNOR

DIVISION OF HEALTH POLICY AND FINANCE

Function of State Agency

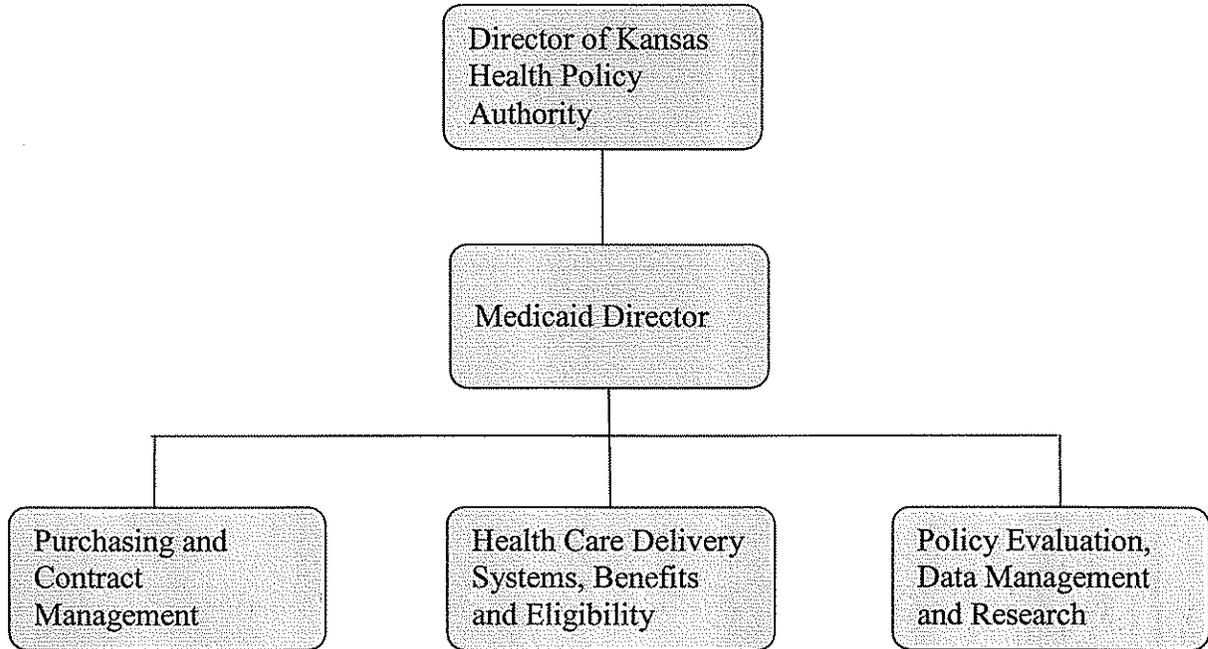
Kansas Health Policy Authority

The Authority recognizes the importance in providing access to health care coverage to eligible, needy Kansans, and serving as the gatekeeper for Medicaid, the State Children's Health Insurance Program, and MediKan funds as the single state Medicaid agency.

The Kansas Health Policy Authority views its mission as bringing the health care community together to develop a comprehensive approach to address issues of health care cost, quality, and accessibility.

TN #06-04 Approval Date MAY 31 2006 Effective Date 07/01/06 Supersedes TN #05-04

Kansas Health Policy Authority



ATTACHMENT 1.2-B

Administration of Medicaid Program

KANSAS MEDICAID STATE PLAN

Attachment 1.2-B

Page 1

ADMINISTRATION OF THE MEDICAID PROGRAM

The Kansas Health Policy Authority (KHPA) is the Single State Agency responsible for the Medicaid Program in Kansas. The Authority has direct administrative responsibility for the Medicaid program, although certain long-term care services (e.g., nursing facilities, HCBS waivers) are managed on a day-to-day basis by the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services (SRS). Some eligibility determination work is also performed by SRS, in regional service centers, following policy direction laid out by KHPA.

The Executive Director of KHPA has responsibility and statutory authority for the oversight of the Medicaid Program. The Executive Director is supported by the Medicaid Director, the Medical Director and three (3) Unit Administrators.

The Administrator of Health Care Delivery Systems, Benefits, and Eligibility is responsible for Medicaid services policy development, capitated managed care, primary care case management, and eligibility policy development and training.

The Administrator of Policy Evaluation, Data Management, and Research is responsible for establishing reimbursement rates, computing the fiscal impact of proposed policies, establishing DRGs for inpatient hospital services, establishing capitation rates for management care, and researching proposed coverage options.

The Administrator of Purchasing and Contract Management is responsible for fiscal agent operations, eligibility clearinghouse operations, administrative appeals, state regulations, the Medicaid State Plan, oversight of SURS activities, estate recovery, developing and managing contracts, and performing project management activities.

ATTACHMENT 1.2-C

Professional Medical and Supporting Staff

KANSAS MEDICAID STATE PLAN

Attachment 1.2-C
Page 1

Federal Financial Participation Staff Time Allocation

The Kansas Health Policy Authority uses an electronic data system to determine the Federal Financial Participation (FFP) allocations for staff within the Division. All professional staff enter data into the report system on a monthly basis and allocate their time to the following categories:

- Approved Advanced Planning Documents (APD);
- Drug Utilization Review (DUR)
- Family Planning;
- MMIS Operations;
- Regular Medicaid Administration; and,
- Skilled Medical Professional.

Staff are instructed that only skilled medical professionals may claim time in that category. Staff must complete their time reporting for each month by the 5th day of the following month.

Supplement 1 to Attachment 1.2-C, Page 1, is a copy of the FFP time reporting data entry screen.

Time Reporting - [FrmMasterInput: Form] Type a question for help

New Record Entry

Use this area to enter new records. Once you have entered the new data, click on: Add New Record

Name:

Project:

Date: to:

Hours:

Use this area to view or delete records.

SUM OF HOURS	PROJECT	DAY	
1	HealthyKids	4/11/2006	X
1	Skill Med Profe.	4/11/2006	X
1	PERM Pilot SCHIP	4/11/2006	X
1	PERM Pilot Medicaid	4/11/2006	X
1	MMIS Operat	4/11/2006	X
1	Med. Admin Regular	4/11/2006	X
1	Indep Living	4/11/2006	X
1	Title XXI	4/11/2006	X
1	APD 16A - NPI	4/10/2006	X
1	APD 18 - Presumptive Disb.	4/10/2006	X
1	APD 19 - Presumptive Elig.	4/10/2006	X
1	APD New	4/10/2006	X

KANSAS MEDICAID STATE PLAN

Attachment 1.2-D

Staff of both the Kansas Health Policy Authority (KHPA) and the Kansas Department of Social and Rehabilitation Services (SRS) are responsible for eligibility determinations under the Medicaid program. An Interagency Agreement has been established between the agencies regarding the provision of eligibility determination.

Staff assigned to an eligibility clearinghouse, a unit with KHPA, perform eligibility functions under the supervision of the Medicaid Director. Functions include determination of initial eligibility, adjustment of eligibility, redetermination of eligibility and related functions. Responsibilities of this unit are generally limited to coverage groups under this State Plan related to the Aid to Families with Dependent Children program.

Staff assigned to regional SRS Service Centers perform eligibility functions under the supervision of Regional Directors. SRS is the Title IV-A agency. Functions include determination of initial eligibility, adjustment of eligibility, redetermination of eligibility and related functions. SRS staff have responsibility for all coverage groups identified in this State Plan.

WAIVERS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care

APR 29 1996

Ms. Janet Schalansky
Deputy Secretary
Kansas Department of Social
and Rehabilitation Services
915 SW Harrison Street
Topeka, Kansas 66612

Dear Ms. Schalansky:

I am pleased to inform you that the Health Care Financing Administration (HCFA) is approving Kansas' request for a modification of its Medicaid Managed Care waiver program authorized under section 1915(b)(1) and (4) of the Social Security Act (the Act). This approval permits Kansas to add local health department primary care clinics as case managers under the HealthConnect portion of the waiver program. This approval also allows the State to require primary care providers to accept minimum caseloads of 10 beneficiaries. We are not approving Kansas' request for semi-annual open enrollment periods since this has been approved in a previously approved modification.

I am approving your request for the modification effective May 5, 1996 through January 30, 1997, which coincides with Kansas' current 2-year waiver authority.

I wish you much success in your continuing activities in this area.

Sincerely,

Rachel Block
Director
Medicaid Managed Care Team

KANSAS

WAIVERS OF STATE PLAN PROVISIONS

WA 83-1R2/KS 01R02
KS01.R03

State: Kansas

Type of Waiver (Submitted 1/4/88)

- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as a Central Broker
- 1915(b)(3) - Sharing of Case Savings (through:)
Additional Services
Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format).
 Home and Community Based Services Waiver (model format).
- 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Primary Care Network waiver for case management services.

Approval Date: 12/13/90

Renewal Date(s): for 2 yrs until
8/30/90, 12/27/92

Effective Date: 12/28/90

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: 1902(a)(10)(B), not waived.

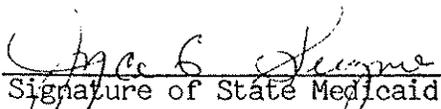
Statewideness: 1902(a)(1), yes, waived. Waiver applies to 7 urban counties.

Freedom of Choice: 1902(a)(23), yes, waived. PCN case management provide or refer medical care.

Services: Case management consisting of primary medical care, and the responsibility for authorizing, locating, coordinating and monitoring all medical care for assigned recipients.

Eligibility: Not waived. Waiver applies to all Medicaid recipients except Medicare/Medicaid (dual) beneficiaries, adult care home residents and foster care recipients.

Reimbursement Provisions (if different from approved State Plan Methodology):
Monthly fee to physicians for providing case management.



Signature of State Medicaid Director
Joyce C. Sugrue

KANSAS

WAIVERS OF STATE PLAN PROVISIONS

KS WA 82-1/0018.901111.01

State: Kansas

Type of Waiver

- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as a Central Broker
- 1915(b)(3) - Sharing of Case Savings (through:)
 - Additional Services
 - Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format).
 - Home and Community Based Services Waiver (model format).
- 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Home and Community Based Services waiver for the elderly or disabled who are eligible for nursing facility placement. This waiver provides services to prevent nursing facility placement and to provide home or community placement if these are cost effective compared to NFs.

Approval Date: 03/22/82 3/26/91

Renewal Date(s): 03/22/85
03/22/88 - Continued
from 03-23-88 to 06-30-88
07-01-88 until 06-30-95

Effective Date: 03/22/82 7/1/88

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: Yes

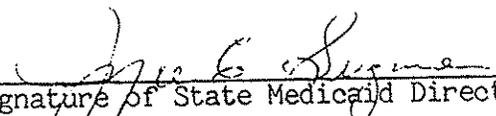
Statewideness: Not waived.

Freedom of Choice: Not waived.

Services: Adult day health, adult failure alarm system, case management, habilitation, homemaker, medical attendant, night support, nonmedical attendant care, prescreening, residential care, residential care and training, residential personal care, respite care and wellness monitoring.

Eligibility: Elderly or disabled recipients who are eligible for nursing facility placement.

Reimbursement Provisions (if different from approved State Plan Methodology):
Fee for service not to exceed the maximum rate established for the procedure.



Signature of State Medicaid Director
Joyce C. Sugrue

KANSAS

WAIVERS OF STATE PLAN PROVISIONS

40165

State: Kansas

Type of Waiver

- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as a Central Broker
- 1915(b)(3) - Sharing of Case Savings (through:)
 - Additional Services
 - Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format).
 - Home and Community Based Services Waiver (model format).
- 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

HCBS Model Waiver for Technology-Assisted Children. This is designed to provide medical case management, medical respite care and DME not otherwise covered in the Kansas Medicaid State Plan to ventilator-dependent children under 16 years of age who would not otherwise survive without the services provided in a hospital setting.

Approval Date: 03-01-91 1/28/91

Renewal Date(s): None yet.

Effective Date: 03-01-91

Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: 1902(a)(10)(b). This waiver's services are not comparable in amount, duration and scope.

Statewideness: Not waived.

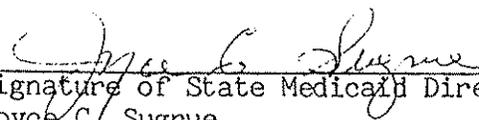
Freedom of Choice: Not waived.

Services: Medical case management, medical respite care and DME not otherwise covered in the Kansas Medicaid State Plan.

Eligibility: 1915(c)(3). Institutional deeming rules will be applied to those meeting the medical definition in the waiver.

Reimbursement Provisions (if different from approved State Plan Methodology):

Fee for service not to exceed the maximum rate established for the procedure.



 Signature of State Medicaid Director
 Joyce C. Sugrue

KANSAS

WAIVERS OF STATE PLAN PROVISIONS

0224

State: KansasType of Waiver

- 1915(b)(1) - Case Management System
 1915(b)(2) - Locality as a Central Broker
 1915(b)(3) - Sharing of Case Savings (through:)
 Additional Services
 Elimination of Copayments
 1915(b)(4) - Restriction of Freedom of Choice
 1915(c) - Home and Community-Based Services Waiver (non-model format).
 Home and Community Based Services Waiver (model format).
 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

HCBS waiver to provide services to MR/DD individuals. Waiver designed to provide habilitation, residential and support services to ICF/MR-eligible individuals age 5 and up.

Approval Date: January 29, 1991Renewal Date(s):Effective Date: July 1, 1991Specific State Plan Provisions Waived and Corresponding Plan Section(s):

Comparability: 1902(a)(10)(B). This waiver's services are not comparable to amount, duration and scope.

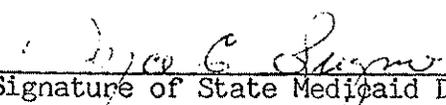
Statewideness: Not waived.

Freedom of Choice: Not waived.

Services: Case management services, habilitation services, respite care, supported employment, residential habilitation, supportive home care, supported family living, home and vehicle modification services, wellness monitoring and medical alert.

Eligibility: 1915(c)(3). Institutional deeming rules will be applied to children ages 5-18.

Reimbursement Provisions (if different from approved State Plan Methodology):
 Fee for service based upon an established rate for each service.



 Signature of State Medicaid Director
 Joyce C. Sugrue



STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WINSTON BARTON, SECRETARY

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

November 1, 1988

Mr. Edward M. Brennan
Associate Regional Administrator
Division of Program Operations
Health Care Financing Administration
Department of Health and Human Services
Room 220, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

Per your letter of September 28, 1988, regarding a PCN waiver summary sheet, Kansas is submitting a revised waiver summary sheet. In accordance with instructions from Judith Flynn of your office, revisions to the summary sheet are handwritten.

Also, according to Ms. Flynn, this document has not been assigned a Kansas Medicaid State Plan transmittal number. Instead, a copy of this page has been retained in our offices, and has been placed at the very front of the plan, before the table of contents.

Any questions may be directed to Sally Adams at (913) 296-3981.

Sincerely,

L. Kathryn Klassen
L. Kathryn Klassen, R.N., M.S.
Director
Division of Medical Programs

LKK:SA:plk
cc: Steve Otto

Attachment

WAIVERS OF STATE PLAN PROVISIONS

WA 83-1R2/KS 01R02

State:

Type of Waiver (Submitted 1/4/88)

- 1915(b)(1) - Case Management System
- 1915(b)(2) - Locality as a Central Broker
- 1915(b)(3) - Sharing of Cost Savings (through:
 - Additional Services
 - Elimination of Copayments
- 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - Home and Community-Based Services Waiver (non-model format).
 - Home and Community-Based Services Waiver (model format).
- 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

Primary Care Network waiver for ~~AFDC and AFDC-related recipients.~~ *case management services.*

Approval Date: 8/29/88

Renewal Date(s): for 2 yrs until 8/30/90

Effective Date: 8/30/88

Specific State Plan Provisions Waived and Corresponding Plan Section(s)

Comparability: 1902(a)(10)(B)

Statewideness: 1902(a)(1)

Freedom of Choice: 1902(a)(23)

Services: *Case Management consisting of primary medical care, and the responsibility for authorizing, locating, coordinating and monitoring all medical care for assigned recipients.*

Eligibility: ~~AFDC and AFDC-related recipients~~ *all medical recipients except Medicare/Medicaid (dual) beneficiaries, adult care home residents and foster care recipients.*

Reimbursement Provisions (if different from approved State Plan Methodology):

Monthly fee to physicians for providing case management.

X L. Kathryn Klassen
Signature of State Medicaid Director

not included
in other
books

INCOME SUPPORT/
MEDICAL SERVICES
8845 Security Boulevard
Baltimore, MD 21207

05 JUN 18 AM 10:13

6

KANSAS SOCIAL AND
REHABILITATION SERVICES

JUN 17 1996

OFFICE OF THE
SECRETARY

Ms. Rochelle Chronister
Secretary
Kansas Department of Social
and Rehabilitation Services
915 SW Harrison Street
Topeka, Kansas 66612

Dear Ms. Chronister:

I am pleased to inform you that your request for a Medicaid waiver to provide home and community-based services to frail elderly individuals (FE), as authorized under the provisions of section 1915(c) of the Social Security Act, has been approved. This waiver has been assigned control number 0303 which should be used in any subsequent correspondence.

Specifically, you submitted a waiver request to provide respite care, personal emergency response systems, adult day care, sleep cycle support, health care attendant (Levels I and II), and wellness monitoring. You also requested a waiver of section 1902(a)(10)(B) of the Act which deals with "comparability" of services.

Based on the assurances and information you provided, including the additional clarifying information in response to our concerns, I approve the waiver request cited above for a 3-year period effective January 1, 1997. With a satisfactory showing, the waiver may be renewed at the end of the 3-year period. The following estimates of the average per capita cost of waiver services and unduplicated recipients have been approved.

YEAR	FACTOR D	UNDULICATED RECIPIENTS
1	4,373	9,338
2	4,499	9,712
3	4,629	10,100



INCOME SUPPORT/
MEDICAL SERVICES

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

APR 03 1997

97 APR -7 PM 12:16

cc: Kael

Ms. Janet K. Schalansky
Deputy Secretary
Kansas Department of Social
and Rehabilitation Services
915 SW Harrison Street
Topeka, Kansas 66612

Dear Ms. Schalansky:

I am pleased to inform you that your request to amend Kansas' home and community-based services frail elderly waiver has been approved. The amendment has been given control number 0303.01.

Specifically, you asked to amend the waiver to revise the amount the State is protecting for the maintenance needs of the waiver recipient under regular post-eligibility and spousal impoverishment post-eligibility rules. You are also covering the special HCBS waiver eligibility group specified at 435.217 and including a special income level equal to 300% of the SSI FBR.

In addition, you are amending the provider qualifications for health care attendant services to allow a spouse, who has received specialized training, to provide health maintenance activities (Level II) when they are delegated by a physician or registered nurse and are documented in the plan of care.

You also have made minor changes to the assessment instrument, the plan of care form, and in the administrative process governing consumer rights and responsibilities under the waiver. In addition, the title of your freedom of choice form is revised to indicate that it is used for both the Frail Elderly and the Physically Disabled waiver programs.

The waiver amendment request, and the additional clarifying information the State provided us, conform fully to the requirements of the statute and Medicaid regulation. Therefore, I am approving the amendment request effective January 1, 1997. We appreciate the effort and cooperation provided by you and your staff.

Sincerely yours,

Judith D. Moore
for Judith D. Moore
Acting Director
Medicaid Bureau

cc: Kansas City Regional Office

KANSAS SOCIAL AND
REHABILITATION SERVICES

APR 07 1997

OFFICE OF THE
SECRETARY



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6326 Security Boulevard
Baltimore, MD 21207

June 18, 1996

Ms. Rochelle Chronister
Secretary, Kansas Department of Social and Rehabilitation Services
915 SW Harrison Street
Topeka, Kansas 66612

Dear Ms. Chronister:

I am pleased to inform you that your request for a Medicaid waiver to provide home and community-based services, as authorized under Section 1915(c) of the Social Security Act, to physically disabled adults has been approved.

Specifically, you requested a model waiver to provide independent living counseling, personal services, and assistive services to adults, age 16 through 64, with physical disabilities who would otherwise require the level of care provided in a nursing facility. You also requested a waiver of section 1902(a)(10)(B) of the Act which deals with the comparability of services. This waiver has been assigned control number 0304 which should be used in all future correspondence.

Based on the assurances and information you provided, I approve the revised waiver request cited above for a three year period effective January 1, 1997, as requested. With a satisfactory showing, the waiver may be renewed at the end of the three year period. The following estimates of unduplicated recipients and the average per capita cost of waiver services have been approved:

Year	Unduplicated Recipients	Factor D
1	2,608	\$8,226
2	2,712	\$8,578
3	2,821	\$8,824



INCOME SUPPORT/
MEDICAL SERVICES

97 APR -7 PM 12:15

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

APR - 4 1997

Kaci

Ms. Janet K. Schalansky
Deputy Secretary
Kansas Department of Social
and Rehabilitation Services
915 SW Harrison Street
Topeka, Kansas 66612

Dear Ms. Schalansky:

I am pleased to inform you that your request to amend Kansas' home and community-based services waiver which serves individuals with physical disabilities has been approved. The amendment has been given control number 0304.01.

Specifically, you asked to amend the waiver to revise the amount the State is protecting for the maintenance needs of the waiver recipient under regular post-eligibility and spousal impoverishment post-eligibility rules. You have also revised the definition of personal services and the provider qualifications to allow a spouse, who has received specialized training, to provide those personal services identified as health maintenance activities when they are delegated by a physician or registered nurse and are documented in the plan of care. Lastly, you made minor changes to the assessment instrument, the plan of care form, and in the administrative process governing consumer rights and responsibilities under the waiver. In addition, the title of your freedom of choice form was revised to indicate that it is used for both the Frail Elderly and the Physically Disabled waiver programs.

We have reviewed the amendment and find that it conforms to the applicable Federal requirements. Therefore, I am approving your request to incorporate these changes into Kansas' waiver effective January 1, 1997. We appreciate the effort and cooperation provided by you and your staff.

Sincerely,

Judith D. Moore
Acting Director
Medicaid Bureau

cc: ARA, Kansas City Regional Office

KANSAS SOCIAL AND
REHABILITATION SERVICES

APR 07 1997

OFFICE OF THE
SECRETARY

KANSAS MEDICAID STATE PLAN

Attachment 2.1

(Reserve for future use)

TN # MS #03-08
Supersedes TN # MS #02-10

Effective Date August 1, 2003
Approval Date August 28, 2003

ATTACHMENT 2.2-A

**Groups Covered and Agencies Responsible
For Eligibility Determinations**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

IV-A 42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.

Pregnant women with no other eligible children.

AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

IV-A 42 CFR 435.115

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-88-43

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
		2. Deemed Recipients of AFDC.
IV-A	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
IV-A	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
IV-A	406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
IV-A	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

TN No. MS-91-41 Approval Date 10/1/91 Effective Date OCT 1 1991
Supersedes
TN No. MS-90-19 HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

IV-A 407(b), 1902
(a)(10)(A)(i)
and 1905(m)(1)
of the Act

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

X * Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

IV-A 1902(a)(52)
and 1925 of
the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Per T/C--Bonnie Bailey-Howard W/Dennis Priest on 12/04/91

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-90-19

Approval Date JAN 2 1992

Effective Date OCT 8 1 1991

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
Page 3
OMB NO.: 0938-

State: Kansas

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

IV-A 42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

a. Families denied AFDC solely because of income and resources deemed to be available from--

(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

(2) Grandparents;

(3) Legal guardians; and

(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-87-33

Approval Date

JAN 21 1992

Effective Date

POI 2/1/92

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

— Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

— Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

— Not applicable with respect to intermediate care facilities; State did or does not cover this service.

902(a)(10)
A)(i)(III)
and 1905(n) of
the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

Agency that determines eligibility for coverage.

N No. <u>MS-92-08</u>	Approval Date <u>MAY 22 1992</u>	Effective Date <u>JAN 01 1992</u>
Revised <u>MS-91-41</u>		HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
- (3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

1902(a)(10)(A)
(i)(III) and
1905(n) of the
Act

- b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

X Children born after
September 30, 1979
(specify optional earlier date)
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

TN No. MS-94-22
Supersedes
TN No. MS-92-09

Approval Date FEB 13 1995

Effective Date 10-1-94

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a)(10)(A)(i)(IV) and 1902(1)(1)(A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(1)(1)(A) and (B) of the Act. The income level for this group is specified in <u>Supplement 1 to ATTACHMENT 2.6-A.</u>
	X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
	9. Children:
1902(a)(10)(A)(i)(VI) and 1902(1)(1)(C) of the Act	a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
1902(a)(10)(A)(i)(VII) and 1902(1)(1)(D) of the Act	b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.
	<u>Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

** 1902(a)(10)
(A)(i)(V) and
1905(m) of the
Act

10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.

1902(e)(5)
of the Act

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(e)(6)
of the Act

b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

** Provision not applicable to State.

TN No. MS-92-09
Supersedes
TN No. MS-91-41

Approval Date JUN 01 1992 Effective Date 1-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

1902(e)(4)
of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

X a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

X Aged
X Blind
X Disabled

State: Kansas

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

** 435.121

14. b.

Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(1)
of the Act

— Aged
— Blind
— Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

**Provision not applicable to State

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

Approval Date

JAN 27 1992

Effective Date

OCT 01 1991

TN No. MS-87-18

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

XIX	1902(a) (10)(A) (i)(II) and 1905 (q) of the Act	<p>15. Qualified severely impaired blind and disabled individuals under age 65, who--</p> <p>a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or</p> <p>b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--</p> <p>(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;</p> <p>(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;</p> <p>(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;</p>
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*Agency that determines eligibility for coverage.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
Page 6c
OMB NO.: 0938-

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-87-18

Approval Date JAN 27 1991

Effective Date 001 01 1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

** 1619(b)(3)
of the Act

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

**Provision not applicable to State

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-87-18

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- | | | | |
|-----|--------------------|-----|---|
| XIX | 1634(c) of the Act | 16. | Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

<input type="checkbox"/> c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

<input type="checkbox"/> d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility. |
| XIX | 42 CFR 435.122 | 17. | Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act. |
| XIX | 42 CFR 435.130 | 18. | Individuals receiving mandatory State supplements. |

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

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TN No. MS-87-18

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

XIX	42 CFR 435.131	19. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.
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In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

Aged Blind Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-87-18

Approval Date JAN 27 1992

Effective Date OCT 01 1991

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Revision: HCFA-PM-91-4 (BFD)
AUGUST 1991

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OMB NO.: 0938-

State: Kansas

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
XIX	42 CFR 435.132	20. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
XIX	42 CFR 435.133	21. Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

TN No. MS-91-41
Supersedes MS-87-18
Approval Date JAN 27 1992
Effective Date OCT 01 1991

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
Page 7
OMB NO.: 0938-

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

XIX 42 CFR 435.134

22. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-87-18

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- | | | |
|-----|----------------|---|
| XIX | 42 CFR 435.135 | 23. Individuals who -- <ul style="list-style-type: none">a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; andb. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.<ul style="list-style-type: none"><input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.<input type="checkbox"/> Not applicable because the State applies more restrictive eligibility requirements than those under SSI.<input type="checkbox"/> The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. |
|-----|----------------|---|

*Agency that determines eligibility for coverage.

TN No. <u>MS-91-41</u>	Approval Date <u>JAN 27 1992</u>	Effective Date <u>SEP 1 1991</u>
Supersedes		
TN No. <u>MS-87-18</u>		

HCFA ID: 7983E

State: Kansas

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

- | | | | |
|-----|-----------------|-----|---|
| XIX | 1634 of the Act | 24. | Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act. |
|-----|-----------------|-----|---|
- Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.
- The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-87-18

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(d) of the Act

25. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for purposes of title XIX, to be SSI beneficiaries under section 1634(d) of the Act.

Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility or subsequent cost-of-living increases.

The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date DEC 21 1991
Supersedes TN No. MS-87-18

HCFA ID: 7983E

State: KANSAS

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(i)
and 1905(p) of
the Act

25. Qualified Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income does not exceed 100 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

1902(a)(10)(E)(ii),
905(s) and
905(p)(3)(A)(i)
of the Act

26. Qualified disabled and working individuals--

- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
- b. Whose income does not exceed 200 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.
- d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determines eligibility for coverage.

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM- - (MB)

ATTACHMENT 2.2-A
Page 9b

State: Kansas

Agency*	Citation(s)	Groups Covered
<p>A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u></p>		
<p>1902(a)(10)(E)(i) and 1905(p) of the Act</p>	<p>25. Qualified Medicare beneficiaries--</p>	<p>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</p> <p>b. Whose income does not exceed 100 percent of the Federal poverty level; and</p> <p>c. Whose resources do not exceed twice the maximum standard under SSI.</p>
<p>(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)</p>		
<p>1902(a)(10)(E)(ii), 1905(s) and 1905(p)(3)(A)(i) of the Act</p>	<p>26. Qualified disabled and working individuals--</p>	<p>a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the act;</p> <p>b. Whose income does not exceed 200 percent of the Federal poverty level; and</p> <p>c. Whose resources do not exceed twice the maximum standard under SSI.</p> <p>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</p>
<p>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</p>		

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM- - (MB)

ATTACHMENT 2.2-A
Page 9b1

State: Kansas

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(iii)
and 1905(p)(3)(A)(ii)
of the Act

27. Specified low-income Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25.b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

State: KANSAS

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(iii)
and 1905(p)(3)(A)(ii)
of the Act

27. Specified low-income Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and
- c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

*Agency that determines eligibility for coverage.

TN No. <u>MS-93-04</u>	Approval Date <u>APP 20 1993</u>	Effective Date <u>1-1-93</u>
Supersedes <u>---</u>		
TN No. <u>---</u>		

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy

** 42 CFR 1. Individuals described below who meet the
435.210 income and resource requirements of AFDC,
1902(a) SSI, or an optional State supplement as
(10)(A)(ii) and specified in 42 CFR 435.230, but who do not
1905(a) of receive cash assistance.
the Act

The plan covers all individuals as described above.

The plan covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Caretaker relatives
- Pregnant women

XIX 42 CFR 2. Individuals who would be eligible for AFDC,
435.211 SSI or an optional State supplement as
specified in 42 CFR 435.230, if they were
not in a medical institution.

**Provision not applicable to State

*Agency that determines eligibility for coverage.

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Supersedes
TN No. MS-91-38

HCFA ID: 7983E

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 &
1902(e)(2) of the
Act, P.L. 99-272
(section 9517) P.L.
101-508(section
4732)

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization.

(MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

The State elects not to guarantee eligibility.

The State elects to guarantee eligibility. The minimum enrollment period is __ months (not to exceed six).

The State measures the minimum enrollment period from:

- The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.
- The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.
- The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

State: Kansas

Agency*	Citation(s)	Groups Covered
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1932(a)(4) of
Act

B. Optional Groups Other Than Medically Needy
(continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

 Disenrollment rights are restricted for a period of months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

 X No restrictions upon disenrollment rights.

1903(m)(2)(H),
1902(a)(52) of
the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

 X The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

 The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

State: Kansas

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

XIX 42 CFR
435.217

4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*Agency that determines eligibility for coverage.

TN No. MS-91-41

Supersedes

TN No. MS-86-41

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Effective Date OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

** 1902(a)(10)
(A)(ii)(VII)
of the Act

5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
 - 21
 - 20
 - 19
 - 18
- Caretaker relatives
- Pregnant women

*Agency that determines eligibility for coverage.
**Provision not applicable to State

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.220



6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.



The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act



The State covers only the following group or groups of individuals:

___ Individuals under the age of--

- ___ 21
- ___ 20
- ___ 19
- ___ 18

___ Caretaker relatives

___ Pregnant women

42 CFR 435.222

1902(a)(10)(A)(ii) and 1905(a)(i) of the Act

7.

a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 or younger, as indicated below.

- ___ 20
- ___ 19
- ___ 18

HCFA No. MS-92-08

supersedes

Approval Date MAY 22 1992

Effective Date JAN 01 1992

HCFA No. MS-91-41

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

XIX 42 CFR 435.222

X b* Reasonable classifications of individuals described in (a) above, as follows:

X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

X (a) In foster homes (and are under the age of 21).

X (b) In private institutions (and are under the age of 21).

 (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of).

X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

X (3) Individuals in NFs (who are under the age of 21). NF services are provided under this plan.

X (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 21).

*Per T/C--Bonnie Bailey-Howard
W/Dennis Priest on 12/04/91

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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Page 13a
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State: Kansas

Agency*	Citation(s)	Groups Covered
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XIX

B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | |
|----------|-----|---|
| <u>X</u> | (5) | Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of <u>21</u>). Inpatient psychiatric services for individuals under age 21 are provided under this plan. |
| <u>X</u> | (6) | Other defined groups (and ages), as specified in Supplement 1 of <u>ATTACHMENT 2.2-A.</u> |

TN No. MS-91-41

Supersedes

TN No. MS-86-41

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

XIX 1902(a)(10)
 (A)(ii)(VIII)
 of the Act

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
- b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

<input checked="" type="checkbox"/>	21
<input type="checkbox"/>	20
<input type="checkbox"/>	19
<input type="checkbox"/>	18

TN No. MS-91-41

Supersedes

TN No. MS-86-41

Approval Date

JAN 29 1992

Effective Date

OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency* Citation (s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

** 42 CFR 435.223 9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

1902(a)(10)	___	Individuals under the age of--
(A)(ii) and	___	21
1905(a) of	___	20
the Act	___	19
	___	18
	___	Caretaker relatives
	___	Pregnant women

**Provision not applicable to State

TN No. MS-91-41

Supersedes

TN No. MS-86-41

Approval Date JAN 27 1992

Effective Date 01/01/1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

** 42 CFR 435.230 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
 - ___ (1) All aged individuals.
 - ___ (2) All blind individuals.
 - ___ (3) All disabled individuals.

**Provision not applicable to State

TN No. <u>MS-91-41</u>	Approval Date <u>JAN 27 1991</u>	Effective Date <u>OCT 01 1991</u>
Supersedes		
TN No. <u>MS-86-41</u>		

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | |
|----------------|---|---|
| | — | (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| 42 CFR 435.230 | — | (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| | — | (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| | — | (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| | — | (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| | — | (9) Individuals in additional classifications approved by the Secretary as follows: |

TN No. MS-91-41

Supersedes

TN No. MS-86-41

Approval Date JAN 27 1992

Effective Date SEP 01 1991

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
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OMB NO.: 0938-

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

 Yes.

 No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

TN No. MS-91-41

Supersedes

TN No. MS-86-41

Approval Date

JAN 27 1992

Effective Date

OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.230
435.121
1902(a)(10)
(A)(ii)(XI)
of the Act

11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:
 - ___ (1) All aged individuals.
 - ___ (2) All blind individuals.
 - ___ (3) All disabled individuals.

N No. MS-92-08

supersedes

N No. MS-91-41

Approval Date MAY 2 2 1992

Effective Date JAN 0 1 1992

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | |
|---|-----|---|
| — | (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (7) | Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (9) | Individuals in additional classifications approved by the Secretary as follows: |

TN No. MS-91-41
Supersedes
TN No. MS-86-41

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

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AUGUST 1991

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State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

TN No. <u>MS-91-41</u>	Approval Date <u>JAN 27 1992</u>	Effective Date <u>01/27/92</u>
Supersedes		
TN No. <u>MS-86-41</u>		

HCFA ID: 7983E

State: Kansas

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

XIX	42 CFR 435.231 1902(a)(10) (A)(ii)(V) of the Act	<input checked="" type="checkbox"/> 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.
		<input checked="" type="checkbox"/> The State covers all individuals as described above.
		<input type="checkbox"/> The State covers only the following group or groups of individuals:
	1902(a)(10)(A) (ii) and 1905(a) of the Act	<input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled <input type="checkbox"/> Individuals under the age of-- <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input type="checkbox"/> 19 <input type="checkbox"/> 18 <input type="checkbox"/> Caretaker relatives <input type="checkbox"/> Pregnant women

TN No. MS-91-41

Supersedes

TN No. MS-91-38

Approval Date

JAN 24 1991

Effective Date

OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(e)(3)
of the Act



13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

1902(a)(10)
(ii)(IX)
and 1902(1)
of the Act



14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

- a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
- b. Infants under one year of age.

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supersedes
HCFA No. MS-91-41

Approval Date MAY 22 1992

Effective Date JAN 01 1992

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AUGUST 1991

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OMB NO.: 0938-

State: Kansas

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

- ** 1902(a)
 (10)(A)
 (ii)(IX)
 and 1902(1)(1)
 (D) of the Act
15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

7 years of age; or

8 years of age.

**Provision not applicable to State

TN No. MS-91-41

Supersedes

TN No. MS-87-18

Approval Date

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AUGUST 1991

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OMB NO.: 0938-

State: Kansas

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

** 1902(a)
 (11)(X)
 and 1902(m)
 (1) and (3)
 of the Act

16. Individuals--
- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
 - b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
 - c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

**Provision not applicable to State

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
Supersedes
TN No. MS-89-16

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Group Covered

B. Optional Coverage Other Than the Medically Needy
(Continued)

1902(a)(47)
and 1920 of
the Act

_____ 17. Pregnant women who are determined by a
"qualified provider" (as defined in
Section 1920(b)(2) of the Act) based on
preliminary information, to meet the
highest applicable income criteria
specified in this plan under ATTACHMENT
2.6-A and are therefore determined to be
presumptively eligible during a presumptive
eligibility period in accordance with Section
1920 of the Act.

1920A of the Act

X 18. Children under age 19 who are determined by
a "qualified entity" (as defined in
1920A(b)(3)(A)) based on preliminary
information, to meet the highest applicable
income criteria.

The presumptive period begins on the day that
the determination is made. If an application
for Medicaid is filed on the child's behalf by the
last day of the month following the month in
which the determination of presumptive
eligibility was made, the presumptive period
ends on the day that the State agency makes a
determination of eligibility based on that
application. If an application is not filed on the
child's behalf by the last day of the month
following the month the determination of
presumptive eligibility was made, the
presumptive period ends on that last day.

KANSAS MEDICAID STATE PLAN

Attachment 2.2-A
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STATE: Kansas

Citation Group Covered

B. Optional Coverage Other Than the Medically Needy
(Continued)

1902(a)(10)(A)
(ii)(XVIII) of the Act

X [23]. Individuals who:

- a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
- b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;
- c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
- d. have not attained age 65.

1920B of the Act

____[24]. Individuals who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be an individual described in 1902 (aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a

KANSAS MEDICAID STATE PLAN

Attachment 2.2-A

Page 23c

STATE: Kansas

determination with respect to the individuals' eligibility for Medicaid, or if the individual does not apply for Medicaid (or a Medicaid application was not made on their behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

KANSAS MEDICAID STATE PLAN

Revision:

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State/Territory: KANSAS

Citation	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A) (ii)(XIII) of the Act	[]	25.	BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XV) of the Act	[X]	26.	TWWIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	[X]	27.	TWWIA Medical Improvement Group - Employed Individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources to not exceed a standard established by the State. See page 12h of Attachment 2.6-A.

NOTE: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.

State: Kansas

Agency* Citation(s) Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301 This plan includes the medically needy.

No.

Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)
(C)(ii)(I)
of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

FN No. MS-92-08
Supersedes
FN No. MS-91-41

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AUGUST 1991

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State: Kansas

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy
(Continued)

XIX 1902(e)(4) of
the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

XIX 42 CFR 435.308

5. a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

- 21
- 20
- 19
- 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

(a) In foster homes (and are under the age of 21).

(b) In private institutions (and are under the age of 21).

TN No. MS-91-41

Supersedes

TN No. MS-91-11

Approval Date

JAN 27 1992

Effective Date

OCT 01 1991

HCFA ID: 7983E

State: Kansas

Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of Medically Needy
(Continued)

- (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of).
- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).
- (3) Individuals in NFs (who are under the age of 21). NF services are provided under this plan.
- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 21).
- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State: Kansas

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy
(Continued)

**	42 CFR 435.310	<input type="checkbox"/>	6. Caretaker relatives.
XIX	42 CFR 435.320 and 435.330	<input checked="" type="checkbox"/>	7. Aged individuals.
XIX	42 CFR 435.322 and 435.330	<input checked="" type="checkbox"/>	8. Blind individuals.
XIX	42 CFR 435.324 and 435.330	<input checked="" type="checkbox"/>	9. Disabled individuals.
**	42 CFR 435.326	<input type="checkbox"/>	10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
XIX	435.340		11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

**Provision not applicable to State

TN No. MS-91-41 Approval Date SEP 27 1991 Effective Date OCT 01 1991
Supersedes
TN No. MS-91-38 HCFA ID: 7983E

Revision: HCFA-PM-91-8 (BPD)
October 1991

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OMB NO.: 0938-

State: Kansas

Citation(s)	Groups Covered
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C. Optional Coverage of Medically Needy
(Continued)

1906 of the
Act

12. Individual required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.

TN No. MS-91-46 Approval Date JAN 30 1992 Effective Date 10/01/91
Supersedes _____
TN No. Nothing

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

TN No. #05-07 Supersedes New Approval Date JAN 01 2006 Effective Date July 1, 2005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

**REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19 AND 18 SHALL INCLUDE:**

1. All children under 21 in the custody of the State who are not residing in a public institution but who would be eligible for financial assistance except for their living arrangement. Custody is defined in the Kansas Statutes Annotated as the "status created by court order or statutes which rests in a custodian, whether an individual or an agency, the right to physical possession of the child, and the right to determine placement of the child, subject to restrictions placed by the court".

2. Children under age 21 who if not for the provision of Home and Community Based waiver services would otherwise be institutionalized.

Substitute per letter dated 8/16/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

COVERAGE OF QUALIFIED MEDICARE BENEFICIARIES

Per Section 1902(a)(10)(E)(i) of the Social Security Act, coverage is provided to individuals:

1. who are entitled to Medicare hospital insurance benefits under Part A;
2. whose income does not exceed the percentage of the official poverty line as specified in section 1905(p)(2)(B) of the Act as amended by Section 4501 (a) of the Omnibus Budget Reconciliation Act (OBRA) of 1990; and
3. whose resources do not exceed twice the SSI resource limit.

Medical assistance for this group is limited to Medicare cost-sharing expenses as defined in Section 1905(p)(3) of the Act. Individuals may be eligible both as a Qualified Medicare Beneficiary and under other eligibility groups in the State Plan. Such dually entitled individuals would be eligible for both Medicare cost-sharing expenses and the full range of Medicaid services provided under the State Plan to members of the eligibility group to which the individual belongs.

TN No. MS-91-11

Approved NOV 18 1991

Effective Date 1-1-91

Supersedes
TN No. MS-89-07

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 3 TO ATTACHMENT 2.2-A
Page 1
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Method for Determining Cost Effectiveness of Caring for
Certain Disabled Children At Home

Provision not applicable to State

TN No. MS-91-41

Supersedes

TN No. MS-90-51

Approval Date JAN 27 1992

Effective Date OCT 01 1991

HCFA ID: 7983E

ATTACHMENT 2.6-A
Eligibility Conditions and Requirements

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. <u>General Conditions of Eligibility</u>
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State/Territory: Kansas

Citation	Condition or Requirement
1905(p) of the Act	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435. c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	3. Is residing in the United States and -- a. Is a citizen; b. Is a qualified alien, as defined in section 431(b) of P.L. 104-193, whose coverage is mandatory under sections 402 and 403 of P.L. 104-193, including those who entered the U.S. prior to August 22, 1996, and those who entered on or after August 22, 1996. <input checked="" type="checkbox"/> Is a qualified alien, as defined in section 431(b) of P.L. 104-193, whose coverage is optional under sections 402 and 403 of P.L. 104-193, including those who entered U.S. prior to August 22, 1996, and those who entered on or after August 22, 1996.

TN No. MS-97-08
Supersedes
TN No. MS-92-08

Approval Date MAY 01 1997

Effective Date 1-1-97
HCFA ID: 7982E

State/Territory: Kansas

Citation	Conditions or Requirement
42 CFR 435.403 1902(b) of the Act	c. Is an alien who is not a qualified alien, as defined in section 431(b) of P.L. 104-193, or who is a qualified alien but is not eligible under the provisions of (b) above. (Coverage is restricted to certain emergency services.)
	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.
	<input checked="" type="checkbox"/> State has interstate residency agreement with the following States:
	California Ohio Tennessee Florida Pennsylvania Texas Iowa New Mexico Wisconsin Kentucky South Dakota
	<input type="checkbox"/> State has open agreement(s).
	<input type="checkbox"/> Not applicable; no residency requirement.

State: Kansas

Citation	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 435.604 19 of the A	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. <input checked="" type="checkbox"/> Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number) except for aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Social Security Act (section 1137(f)).

TM No. MS-92-08
S edes
N No. MS-91-41

Approval Date MAY 22 1992

Effective Date JAN 01 1992

HCFA ID: 7985E

State/Territory: Kansas

Citation	Condition or Requirement
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An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in S1902(a)(I)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

- 42 CFR 435.910 7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

TN No. MS-91-46
Supersedes
TN No. MS-91-41

Approval Date JAN 30 1992

Effective Date 10/01/91

HCFA ID: 7985E

State: Kansas

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 3c
OMB No.: 0938-

State/Territory: Kansas

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

TN No. MS-91-46

Supersedes

TN No. Nothing

Approval Date

JAN 30 1992

Effective Date

10/01/91

HCFA ID: 7985E

State: Kansas

Citation	Condition or Requirement
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B. Posteligibility Treatment of Institutionalized
Individuals' Incomes

1. The following items are not considered in the
posteligibility process:

- | | |
|-----------------------------|---|
| 1902(o) of
the Act | a. SSI and SSP benefits paid under §1611(e)(1)(E)
and (G) of the Act to individuals who receive care
in a hospital, nursing home, SNF, or ICF. |
| Bondi v
Sullivan (SSI) | b. Austrian Reparation Payments (pension (reparation)
payments made under §500 - 506 of the Austrian
General Social Insurance Act). Applies only if
State follows SSI program rules with respect to
the payments. |
| 1902(r)(1) of
the Act | c. German Reparations Payments (reparation payments
made by the Federal Republic of Germany). |
| 105/206 of
P. L. 100-383 | d. Japanese and Aleutian Restitution Payments. |
| 1. (a) of
P.L. 103-286 | e. Netherlands Reparation Payments based on Nazi, but
not Japanese, persecution (during World War II). |
| 10405 of
P.L. 101-239 | f. Payments from the Agent Orange Settlement Fund
or any other fund established pursuant to the
settlement in the In re Agent Orange product
liability litigation, M.D.L. No. 381 (E.D.N.Y.) |
| 6(h)(2) of
P.L. 101-426 | g. Radiation Exposure Compensation. |
| 12005 of
P. L. 103-66 | h. VA pensions limited to \$90 per month under
38 U.S.C. 5503. |

TN No. 98-02
Supersedes _____

Approval Date APR 27 1998

Effective Date 1-1-98

TN No. _____

Citation	Condition or Requirement
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1924 of the Act
435.725
435.733
435.832

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than \$30 for individuals and \$60 for Couples for All Institutionalized Persons.

- a. Aged, blind, disabled:
Individuals \$ 60
Couples \$ 120

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

- b. AFDC related:
Children \$ 60
Adults \$ 120

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

- c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2-A
\$ 60

State: Kansas

Citation

Condition or Requirement

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2. , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

X The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

 The poverty level component is calculated using a percentage greater than the applicable percentage, equal to %, of the official poverty level (still subject to maximum maintenance needs standard).

 The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

TN No. 98-02
Supersedes

Approval Date APR 27 1998

Effective Date 1-1-98

TN No. -----

Revision: HCFA-PM-97-2
December 1997

ATTACHMENT 2.6-A
Page 4c
OMB No.:0938-0673

State: Kansas

Citation	Condition or Requirement
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In determining any excess shelter allowance, utility expenses are calculated using:

- the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or
- the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

- one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

- (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
- (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

TN No. 98-02
Supersedes

Approval Date APR 27 1998

Effective Date 1-1-98

TN No. -----

State: Kansas

Citation Condition or Requirement

435.725
435.733
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:
- a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:
- o AFDC level; or
 - o Medically needy level:

(Check one)

- AFDC levels in Supplement 1
- X Medically needy level in Supplement 1
- Other: \$ _____

- b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

- (I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
- (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725
435.733
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

X No.

____ Yes (the applicable amount is shown on page 5a.)

TN No. 98-02
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December 1997

ATTACHMENT 2.6-A
Page 5a
OMB No.:0938-0673

State: Kansas

Citation	Condition or Requirement
_____	Amount for maintenance of home is: \$ _____.
_____	Amount for maintenance of home is the actual maintenance costs not to exceed \$ _____.
_____	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
_____	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p data-bbox="624 506 1025 533">C. <u>Financial Eligibility</u></p> <p data-bbox="690 558 1529 768">For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.</p> <p data-bbox="690 800 1546 926">For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p data-bbox="690 957 1554 1278"><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.</p>

State: Kansas

Citation	Condition or Requirement
<input checked="" type="checkbox"/>	<u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
<input type="checkbox"/>	<u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
<input type="checkbox"/>	<u>Supplement 4 to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input type="checkbox"/>	<u>Supplement 5 to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input type="checkbox"/>	<u>Supplement 8a to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 11 to ATTACHMENT 2.6-A</u> specifies previously approved income methodologies that are more liberal than the methods of the cash assistance program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	<p>1. <u>Methods of Determining Income</u></p> <p>a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u></p> <p>(1) In determining countable income for AFDC-related individuals, the following methods are used:</p> <p>— (a) The methods under the State's approved AFDC plan only; or</p> <p><u>X</u> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in <u>Supplement §A to ATTACHMENT 2.6-A.</u></p> <p>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p>
1902(e)(6) the Act	<p>(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. <u>Aged individuals.</u> In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: ___ The methods of the SSI program only. <u>X</u> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8A to ATTACHMENT 2.6-A.</u>

State: Kansas

Citation	Condition or Requirement
<input type="checkbox"/>	For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	For institutional couples, the methods specified under section 1611(e)(5) of the Act.
<input type="checkbox"/>	For optional State supplement recipients under \$435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
---	SSI methods only.
---	SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
---	Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.	

State: Kansas

Citation	Condition or Requirement
42 CFR 435.721 and 435.831	c. <u>Blind individuals.</u> In determining countable income for blind individuals, the following methods are used:
1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	— The methods of the SSI program only.
	<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 11 to ATTACHMENT 2.6-A.</u>
	— For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A,</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	— For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	— For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u>
	— For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	— SSI methods only.
	— SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	— Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

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HCFA ID: 7985E

State: Kansas

Citation	Condition or Requirement
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In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

42 CFR 435.721,
and 435.831
1902(m)(1)(B),
(m)(4), and
1902(r)(2) of
the Act

d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 11 to ATTACHMENT 2.6-A.
- For institutional couples: the methods specified under section 1611(e)(5) of the Act.
- For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
- For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Revision: HCFA-PH-91-4 (BPD)
AUGUST 1991

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State: Kansas

Citation	Condition or Requirement
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For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

SSSI methods only.

SSSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

TN No. MS-91-41

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Approval Date

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HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(E) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women, infants, and children.</u> For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--</p> <p>(1) The following methods are used in determining countable income:</p> <p>___ The methods of the State's approved AFDC plan.</p> <p>___ The methods of the approved title IV-E plan.</p> <p><u>X</u> The methods of the approved AFDC State plan and/or any more liberal methods described in <u>Supplement 8a/ to ATTACHMENT 2.6-A.</u></p> <p>___ The methods of ¹¹the approved title IV-E plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. <u>Qualified Medicare beneficiaries.</u> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: <input type="checkbox"/> The methods of the SSI program only. <input checked="" type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 94 to ATTACHMENT 2.6-A.</u> 11 <input type="checkbox"/> For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State: KANSAS

Citation

Condition or Requirement

If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

1905(s) of the Act

- g. (1) Qualified disabled and working individuals.

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

1905(p) of the Act

- (2) Specified low-income Medicare beneficiaries.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

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Page 12b
OMB No.:

State/Territory: Kansas

Citation	Condition or Requirement
** 1902 (u) (h) of the Act	<u>COBRA Continuation Beneficiaries</u> In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: _____ The disregards of the SSI program; _____ The agencies uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

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Supersedes _____

TN No. Nothing

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HCFA ID: 7985E

**--Provision not adopted by State

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Citation	Condition or Requirement
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1902(a)(10)(A)
(ii)(XIII) of the Act

(i) Working Individuals with Disabilities - BBA

In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

N/A

- _____ The methodologies of the SSI program.
- _____ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.
- _____ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

FEB 15 2002

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act	(ii) <u>Working Individuals with Disabilities - Basic Coverage Group - TWWIA</u>

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

The agency applied the following income and/or resource standard(s):

Countable income should not exceed 300% of the Federal poverty level for the size of family involved.

Countable resources shall not exceed \$15,000.00.

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TN # MS #01-13 Approval Date _____ Effective Date 07/01/02 Supersedes TN # New

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Citation	Condition or Requirement
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1902(a)(10)(A)
(ii)(XV) of the Act (cont.)

Income Methodologies

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

- The income methodologies of the SSI program.
- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.
- The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

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1902(a)(10)(A)
(ii)(XV) of the Act (cont.)

Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

_____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.

_____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(A)	<input type="checkbox"/> The agency does not disregard funds in retirement accounts.
	<input checked="" type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	<input type="checkbox"/> The agency uses the resource methodologies of the SSI program.
	<input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act	(iii) <u>Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIA</u>
N/A	In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied: <input type="checkbox"/> The agency does not apply any income or resource standard. <input type="checkbox"/> NOTE: If the above option is chosen, no further eligibility-related options should be elected. <input checked="" type="checkbox"/> The agency applies the following income and/or resource standard(s): <u>Countable income shall not exceed 300% of the Federal Poverty Level for the size of family involved.</u> <u>Countable resources shall not exceed \$15,000.</u>

MAR 08 2005

TN # MS #05-01 Approval Date _____ Effective Date 02/01/05 Supersedes TN # MS#01-13

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<u>Income Methodologies</u> In determining whether an individual meets the income standard described above, the agency uses the following methodologies. <input type="checkbox"/> The income methodologies of the SSI program. <input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. <input checked="" type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

N/A

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p><u>Resource Methodologies</u></p> <p>In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p>
N/A	<p>Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.</p> <p><input type="checkbox"/> The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.</p> <p><input type="checkbox"/> The agency disregards funds in retirement accounts in a manner other than those listed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.</p>

MAR 08 2005

TN # MS #05-01 Approval Date _____ Effective Date 02/01/05 Supersedes TN # MS#01-13

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<input type="checkbox"/> The agency does not disregard funds in retirement accounts.
N/A	<input checked="" type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	<input type="checkbox"/> The agency uses the resource methodologies of the SSI program.
	<input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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TN # MS #05-01 Approval Date _____ Effective Date 02/01/05 Supersedes TN # MS#01-13

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act	<u>Definition of Employed - Employed Medically Improved Individual - TWWIA</u>
N/A	<input checked="" type="checkbox"/> The agency uses the statutory definition of “employed”, i.e., earning at least the minimum wage, and working at least 40 hours per month. <input type="checkbox"/> The agency uses an alternative definition of “employed” that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency’s threshold criteria are described below:

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1902(a)(10)(A)(ii)(XIII)
(XV), (XVI), and 1916(g)
of the Act

N/A

Payment of Premiums or Other Cost Sharing
Charges

For individuals eligible under the BBA eligibility
group described in No. 23 on page 23d of
Attachment 2.2-A:

_____ The agency requires payment of premiums
or other cost-sharing charges on a sliding
scale based on income. The premiums or
other cost-sharing charges, and how they are
applied, are described below.

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1902(a)(10)(A)(ii)(XIII)
(XV), (XVI), and 1916(g)
of the Act (cont.)

For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement Group described in No. 25 and page 23d of Attachment 2.2-A:

NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds \$75,000 pay 100 percent of premiums.

X The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.

The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.

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Sections 1902(a)(10)(A)
(ii)(XV), (XVI), and 1916 (g)
of the Act (cont.)

Premiums and Other Cost-Sharing Charges

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

For individuals with countable income greater than or equal to 100% of the Federal Poverty level for the appropriate family size, a monthly premium amount is assessed. The premium amount is equal to 7.5% of the poverty level indicated for the appropriate family size based on the following range of countable income:

- 100% of FPL for incomes between 100% and 125% of FPL
- 126% of FPL for incomes between 126% and 150% of FPL
- 151% of FPL for incomes between 151% and 175% of FPL
- 176% of FPL for incomes between 176% and 200% of FPL
- 201% of FPL for incomes between 201% and 225% of FPL
- 226% of FPL for incomes between 226% and 250% of FPL
- 251% of FPL for incomes between 251% and 275% of FPL
- 276% of FPL for incomes between 276% and 300% of FPL

FEB 15 2002

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Citation	Condition or Requirement
1902(k) of the Act	<p>2. Medicaid Qualifying Trusts</p> <p>In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p><input type="checkbox"/> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p>3. Medically needy income levels (MNILs) are based on family size.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

State: Kansas

Citation Condition or Requirement

42 CFR 435.732, 4. Handling of Excess Income - Spend-down for the
435.831 Medically Needy in All States and the Categorically Needy
in 1902(f) States Only

a. Medically Needy

- (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either 1 or 6 month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.
- (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:
 - (a) Health insurance premiums, deductibles and coinsurance charges.
 - (b) Expenses for necessary medical and remedial care not included in the plan.
 - (c) Expenses for necessary medical and remedial care included in the plan.

X Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

Refer to Supplement 3 of ATTACHMENT 2.6-A

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Revision: HCFA-PM-91-8 (MB)
October 1991

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State/Territory: Kansas

Citation	Condition or Requirement
1903(f)(2) of the Act	a. <u>Medically Needy (Continued)</u> (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

TN No. MS-91-46

Supersedes

TN No. Nothing

Approval Date

JAN 30 1992

Effective Date

10/01/91

HCFA ID: 7985E/

State: Kansas

Citation

Condition or Requirement

42 CFR
435.732

b. Categorically Needy - Section 1902 (f) States

The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:

- (1) Any SSI benefit received.
- (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.
- (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.
- (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4.
- (5) Incurred expenses for necessary medical and remedial services recognized under State law.

1902(a)(17) of the
Act, P.L. 100-203

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

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Supersedes
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Revision: HCFA-PM-91-8 (MB)
October 1991

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State/Territory: Kansas

Citation	Condition or Requirement
1903(f)(2) of the Act	4.b. <u>Categorically Needy - Section 1902(f) States</u> Continued ____ (6) Spenddown payments made to the State by the individual.

NOTE: FFP will be reduced to the extent a State is
paid a spenddown payment by the individual.

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Supersedes
TN No. Nothing

Approval Date JAN 30 1992

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HCFA ID: 7985E/

State: Kansas

Citation

Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

- (1) In determining countable resources for AFDC-related individuals, the following methods are used:
- (a) The methods under the State's approved AFDC plan; and
 - (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- (2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Kansas

Citation	Condition or Requirement
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5. Methods for Determining Resources

1902(a)(10)(A),
1902(a)(10)(C),
1902(m)(1)(B)
and (C), and
1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State: Kansas

Citation	Condition or Requirement
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In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A),
1902(a)(10)(C),
1902(m)(1)(B), and
1902(r) of the
Act

c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Kansas

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <p>___ The methods of the SSI program.</p> <p><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(1)(3) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <p>___ The methods of the SSI program only.</p> <p>___ The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>

State: Kansas

Citation	Condition or Requirement
---	Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u>
<u>X</u>	Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3) and 1902(r)(2) of the Act	f. <u>Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</u> The agency uses the following methods for the treatment of resources:
---	The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	--- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(r)(2) of the Act	--- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u>
<u>X</u>	Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 1. <u>Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act.</u> The agency uses the following methods for the treatment of resources: — The methods of the State's approved AFDC plan. — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u> — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u> <u>X</u> Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3)(C) of the Act	
1902(r)(2) of the Act	

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Supersedes

TN No.

MS-91-41

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Effective Date

1-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 2. <u>Poverty level children under section 1902(a)(10)(A)(i)(VII)</u> The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan.
1902(1)(3)(C) the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(r)(2) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>
	<u>X</u> Not applicable. The agency does not consider resources in determining eligibility.

In determining relative responsibility, the
agency considers only the resources of spouses
living in the same household as available to
spouses and the resources of parents as
available to children living with parents until
the children become 21.

State: Kansas

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. <u>Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act</u> the agency uses the following methods for treatment of resources: — The methods of the SSI program only. <u>X</u> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
**1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: — The methods of the SSI program only. — More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

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TN No. MS-91-41

Approval Date JAN 30 1992

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**Provision not adopted by State.

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Revision: HCFA-PM-93-5 (MB)
May 1993

State/Territory: Kansas

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	<p>k. <u>Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act --</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p>
	<p>6. Resource Standard - Categorically Needy</p> <p>a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:</p> <p>_____ Same as SSI resource standards.</p> <p>_____ More restrictive.</p> <p>The resource standards for other individuals are the same as those in the related cash assistance program.</p>
	<p>b. Non-1902(f) States (except as specified under items 6.c. and d. below)</p> <p>The resource standards are the same as those in the related cash assistance program.</p> <p><u>Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.</u></p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	<p>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(i)(IX) of the Act, the agency applies a resource standard.</p> <p><u> </u> Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u> X </u> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act	<p>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</p> <p><u> </u> Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u> X </u> No. The agency does not apply a resource standard to these individuals.</p>

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State: Kansas

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	** e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(i)(X) of the Act, the resource standard is: — Same as SSI resource standards. — Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

**Provision not applicable to State

TN No. MS-91-41

Supersedes

Approval Date JAN 27 1992

Effective Date OCT 01 1991

TN No. MS-87-18

HCFA ID: 7985E

KANSAS MEDICAID STATE PLAN

Attachment 2.6-A
Page 22

Revision: HCFA-PM-93-5 (MB)
May 1993

State/Territory: Kansas

Citation	Condition or Requirement
----------	--------------------------

7. Resource Standard - Medically Needy

1902(a)(10)(C)(i)
of the Act

- a. Resource Standards are based on family size.
- b. A single standard is employed in determining resource eligibility for all groups.
- c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for --

- _____ Aged
- _____ Blind
- _____ Disabled

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.

1905(p)(1)(D)
and (p)(2)(B)
of the Act

8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act and specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, the resource standard is twice the SSI standard.

1905(s) of the Act

9. Resource Standard - Qualified Disabled and Working Individuals

For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or A couple (in the case of an individual with a spouse) is twice the SSI resource standard..

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 22a
OMB No.:

State/Territory: Kansas

Citation	Condition or Requirement
**1902(u) of the Act	9.1 For COBRA continuation beneficiaries, the resource standard is: ____ Twice the SSI resource standard for an individual. ____ More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

TN No. MS-91-46
Supersedes
TN No. MS-91-41

Approval Date 10/01/91

Effective Date 10/01/91

HCFA ID: 7985E

**Provision not adopted by State.

KANSAS MEDICAID STATE PLAN

Attachment 2.6-A
Page 23

Revision: HCFA-PM-93-5 (MB)
May 1993

State/Territory: Kansas

Citation	Condition or Requirement
1902(u) of the Act	<p>10. Excess Resources</p> <p>a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries</p> <p>Any excess resources make the individual ineligible.</p> <p>b. Categorically Needy Only</p> <p>_____ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.</p> <p>c. Medically Needy</p> <p>Any excess resources make the individual ineligible.</p>

State: Kansas

Citation	Condition or Requirement
----------	--------------------------

42 CFR
435.914

11. Effective Date of Eligibility
- a. Groups Other Than Qualified Medicare Beneficiaries
- (1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

Aged, blind, disabled.
 AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

Aged, blind, disabled.
 AFDC-related.

- (2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

Aged, blind, disabled.
 AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

Aged, blind, disabled.
 AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: KANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	<p><u> </u> (3) For a presumptive eligibility for pregnant women only.</p> <p>Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</p>
1902(e)(8) and 1905(a) of the Act	<p><u> X </u> b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--</p> <p><u> X </u> 12 months</p> <p><u> </u> 6 months</p> <p><u> </u> months (no less than 6 months and no more than 12 months)</p>

Citation	Condition or Requirement
1902(a)(18) And 1902(f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A</u>.</p>
1917(c)	<p>13. Transfer of Assets – All eligibility groups</p> <p>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</p> <p>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to Attachment 2.6-A</u>, except in instances where the agency determines that the transfer rules would work an undue hardship.</p>
1917(d)	<p>14. Treatment of Trusts – All eligibility groups</p> <p>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p>— The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;</p> <p>— The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of <u>Miller</u> trusts.</p> <p>The agency does not count the funds in a trust in any instances where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 10 to Attachment 2.6-A</u>.</p>

Revision: HCFA-PM-97-3
December 1997

ATTACHMENT 2.6-A
Page 26a
OMB No.:0938-0673

State: Kansas

Citation _____ Condition or Requirement _____

1924 of the Act

13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

the maximum standard permitted by law;

the minimum standard permitted by law; or

a standard that is an amount between the minimum and the maximum.

TN No. 98-02
Supersedes

Approval Date APR 27 1998

Effective Date 1-1-98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: KANSAS

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size Need Standard Payment Standard Maximum Payment Amounts

Persons in Plan	I & II		III		IV		V	
	100%	185%	100%	185%	100%	185%	100%	185%
	1	224	414	229	423	241	445	267
2	309	571	314	580	326	603	352	651
3	386	714	391	723	403	745	429	793
4	454	839	459	849	471	871	497	919
5	515	952	520	962	532	984	558	1032
6	576	1065	581	1074	593	1097	619	1145
7	637	1178	642	1187	654	1209	680	1258
8	698	1291	703	1300	715	1322	741	1370

For each additional person, add \$61 to the 100% column and \$112 to the 185% column.

Persons in Plan	I & II		III		IV		V	
	100%	185%	100%	185%	100%	185%	100%	185%
	1	168	310	170	314	175	323	186
2	263	486	265	490	271	501	284	525
3	349	645	352	651	359	664	375	693
4	421	778	425	786	432	799	449	830
5	487	900	490	906	499	923	517	956
6	557	1030	561	1037	571	1056	592	1095
7	618	1143	622	1150	632	1169	653	1208
8	679	1256	683	1263	693	1282	714	1320

For each additional person, add \$61 to the 100% column and \$112 to the 185% column.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

B. INCOME ELIGIBILITY LEVELS - OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES UP TO FEDERAL POVERTY LINE

1. Pregnant Women, Infants, and Children

The levels for determining income eligibility for groups of pregnant women, infants, and children under the provisions of section 1902(1)(2) of the Act are as follows:

Based on 150 percent of the official Federal nonfarm income poverty line for pregnant women and infants.

Based on 133 percent of the official Federal nonfarm income poverty line for children ages 1 to 6.

Based on 100 percent of the official Federal nonfarm income poverty line for children born after September 30, 1983 who have attained six years of age but not attained 19 years of age.

TR No. MS-91-38
Supersedes
TR No. MS-90-19

Approval Date OCT 16 1991

Effective Date 1-1-91

HCPA ID: 1038P/0013r

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: KANSAS

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants N/A

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on _____ percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 8 N/A

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(1)(2) of the Act are as follows:

Based on _____ percent (no more than 100 percent) of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____
<u>6</u>	\$ _____
<u>7</u>	\$ _____
<u>8</u>	\$ _____
<u>9</u>	\$ _____
<u>10</u>	\$ _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals N/A

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

TN No. MS-92-09
Supersedes
TN No. MS-91-41

Approval Date JUN 01 1992

Effective Date 1-1-92

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

INCOME ELIGIBILITY LEVELS (Continued)

3. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

- Eff. Jan. 1, 1989: 80 percent _____ percent (no more than 100)
- Eff. Jan. 1, 1990: 85 percent _____ percent (no more than 100)
- Eff. Jan. 1, 1991: 95 percent _____ percent (no more than 100)
- Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

1
2

\$ _____
\$ _____

FN No. MS-92-08
Supersedes
FN No. MS-91-41

Approval Date MAY 22 1992

Effective Date JAN 01 1992

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

Applicable to all groups.

Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for Maintenance for <u>6</u> months.	Amount by which Column (2) exceeds limits Specified in <u>45 CFR</u> 435.100 <u>1/</u>	Net income level for persons living in rural areas <u> </u> months.	Amount by which (Column (4) exceeds limits specified in <u>42 CFR</u> 435.100 <u>1/</u>

Urban Only

Urban & Rural

1.	\$475	\$	\$	\$
2.	\$475	\$	\$	\$
3.	\$480	\$	\$	\$
4.	\$497	\$	\$	\$

For each additional person, add:

\$ 61	\$	\$	\$
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1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN No. MS-97-08
 Supersedes
 TN No. MS-96-02

Approval Date MAY 01 1997

Effective Date 1-1-97
 HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1) Family Size	(2) Net income level protected for maintenance for 6 months	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007 ^{1/}	(4) Net income level for persons living in rural areas for 6 months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 ^{1/}
<input type="checkbox"/> urban only				
<input type="checkbox"/> urban & rural				
5	\$ 558	\$	\$	\$
6	\$ 619	\$	\$	\$
7	\$ 680	\$	\$	\$
8	\$ 741	\$	\$	\$
9	\$ 802	\$	\$	\$
10	\$ 863	\$	\$	\$
For each additional person, add:	\$ 61	\$	\$	\$

^{1/} The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL
N/A

1. Pregnant Women

a. Mandatory Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____

b. Optional Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

2. Infants N/A

a. Mandatory Group of Infants

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

b. Optional Group of Infants N/A

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
Supersedes
TN No. MS-87-18 HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

3. Children N/A

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

___ Same as resource levels in the State's approved AFDC plan.

___ Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

- * b. Mandatory Group of Children under Section 1902(a)(10)(A)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

___ Same as resource levels in the State's approved AFDC-plan.

___ Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

* Kansas does not apply an assets test to this group.

TN No. MS-92-12
Supersedes Approval Date _____ Effective Date 05/01/92
TN No. MS-91-41

MAY 18 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

4. Aged and Disabled Individuals N/A

Same as SSI resource levels.

More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____

Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDED

Applicable to all groups -

Except those specified below under the provisions of section 1902(f) of the Act.

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>2000</u>
<u>2</u>	<u>3000</u>
<u>3</u>	<u>3000</u>
<u>4</u>	<u>3000</u>
<u>5</u>	<u>3000</u>
<u>6</u>	<u>3000</u>
<u>7</u>	<u>3000</u>
<u>8</u>	<u>3000</u>
<u>9</u>	<u>3000</u>
<u>10</u>	<u>3000</u>
For each additional person	<u>----</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

**REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID**

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

TN # MS #07-10
Supersedes TN # MS #03-08

Effective Date April 1, 2007
Approval Date JUL 19 2007

Revision: HCFA-PH-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 4 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

N/A

TN No. MS-91-41
Supersedes MS-87-18 Approval Date JAN 27 1992 Effective Date 001 1 1992

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 5 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

N/A

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date OCT 01 1991
Supersedes
TN No. HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 5a TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

N/A

TN No. MS-91-41 Approval Date JAN 27 1992 Effective Date _____
Supersedes _____
TN No. MS-87-18 HCFA ID: 7985E

Revision: HCFA-AT-85-3
 FEBRUARY, 1985

SUPPLEMENT 6 TO
 Attachment 2.6-A

State KANSAS

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level			Income Disregards Employed
	Federal	State	<u>Gross</u> 1 per- son	Couple	<u>Net</u> 1 per- son	
(1)	(2)		(3)		(4)	(5)

TN# MS-85-11
 Supersedes
 TN# MS-81-7

Approval Date 10/9/85

Effective Date 4/1/85

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 7 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

N/A

TN No. MS-91-41
Supersedes MS-85-11
Approval Date JAN 27 1992
Effective Date OCT 01 1991
HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 8 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

N/A

FN No. MS-91-41
supersedes

Approval Date

JAN 2 1991

Effective Date

OMB No. 7985E

*Substitute per letter dated 11/19/01 30

Revision: HCFA-PM91-4 (BPD)

SUPPLEMENT 8a TO ATTACHMENT 2.6-A

Page 1

Omb No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

**MORE LIBERAL METHODS OF TREATING INCOME
UNDER THE SECTION 1902(r)(2) OF THE ACT**

Section 1902 (f) State

Non-Section 1902 (f) State

- For qualified children under 1902 (a)(10)(A)(i)(III) of the Act who are defined in 1905(n)(2) of the Act, countable income which is in excess of AFDC standards as of July 16, 1996 but not in excess of 100% of the federal poverty level is disregarded.
- For all eligibility groups subject to 1902(r)(2).

Lump sum payments are excluded as income but are countable resources if retained in the month following the month of receipt

Interest income which does not exceed \$50.00 a month is exempt

The earnings of a child under the age of 18 are exempt

Deduct either a standard amount equal to 25% of gross earned income or actual income producing costs for unearned income resulting from self-employment. When this income is produced from active management of property or active production of income, allow in addition, the earned income disregard appropriate for the coverage group.

Income-in-kind is exempt in full.

The first \$50.00 per month of irregular, occasional or unpredictable gift income is exempt.

- All interest earned on an IDA account funded under the Assets for Independence Act is excluded.
- All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

***More liberal methods may not result in exceeding gross income limitations under Section 1903(f).**

Substitute per letter dated 11/19/01™

HCFA-PM91-4

BPD)

SUPPLEMENT 8b TO ATTACHMENT 2.6-A

Page 1

Omb No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

**MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER THE SECTION 1902(r)(2) OF THE ACT**

Section 1902 (f) State

Non-Section 1902 (f) State

I. More liberal resource exemptions

- For the aged, blind and disabled, if a person enters an institutional living arrangement for long term care, the home shall retain its exempt status for 3 months (including the month of entrance) provided the person does not intend to return to the home and there is no spouse of other dependent family member who continues to live in the home. This provision is in addition to the home exemption policies of the SSI program.
- For aged, blind and disabled individuals, personal effects and keepsakes and household equipment and furnishings are exempt without regard to value.
- For aged, blind disabled individuals, one car is exempt regardless of value. Additional vehicles may be exempt if shown to be essential for employment of self-support, used as the family's home, for medical treatment, or if specially equipped for use by a handicapped person.
- For aged, blind and disabled individuals, property (both real and personal) which is essential for employment or self-employment or which produces income consistent with its fair market value.
- For children under 1902(a)(10)(ii)(I) of the Act, the countable resources of all members of the medical assistance plan are excluded. (Medically needy children)
- For pregnant women under 1902(a)(10)(C)(ii)(II) of the Act, the countable resources of all members of the medical assistance plan are excluded. (Medically needy pregnant women)
- For all eligibility groups all funds in IDA accounts funded under the Assets for Independence Act are excluded.

II. More liberal methodologies for treatment of resources

- For aged, blind and disabled individuals, if an individual owns excess nonexempt real or personal property (other than liquid cash assets), assistance can be provided up to 9 months while the individual is making a bona fide effort to dispose of the property.
- For aged, blind and disabled individuals, resource value shall be viewed throughout the month and if the individual is resource eligible for 1 day in the month, he or she is eligible for the entire month.
- For pregnant women, children and aged, blind and disabled individuals, resources that an individual owns jointly with a non-legally responsible person shall not be considered if the individual can demonstrate that he or she has no ownership interest in the resource, has not contributed to the resource, and that his or her access to the resource is limited to acting as an agent for the other person. It is not a requirement that the individual also remove his or her name from the title for the resource to not be considered.

TN MS #01-19 Approval Date NOV 20 2001 Effective Date 07/01/01 Supersedes MS #97-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) The following more liberal methodology applies to individuals who are
1917(b)(1)(C) eligible for medical assistance under one of the following eligibility
groups:

1902(a)(10)(A)(ii)(V)	Individuals residing in a medical institution under a special income level
1902(a)(10)(C)	Medically Needy
1902(a)(10)(A)(ii)(XV)	TWWIIA Basic Coverage Group
1902(a)(10)(A)(ii)(XVI)	TWWIIA Medical Improvement Coverage Group
1902(a)(10)(E)(i)	Qualified Medicare Beneficiaries
1902(a)(10)(E)(iii)	Specified Low Income Medicare Beneficiaries
1902(a)(10)(E)(iv)(I)	Qualified Individuals-I

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

TN # 07-02 Approval Date APR 27 2007 Effective Date 04/01/07 Supersedes # New

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

TRANSFER OF RESOURCES

1902(f) and 1917
of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. X The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

Refer to pages 7a - 7c.

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AUGUST 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

b. The period of ineligibility is less than 24 months, as specified below:

Refer to pages 7a - 7c.

c. The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

Refer to pages 7a - 7c.

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AUGUST 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

2. Transfer of the home of an individual who is an inpatient in a medical institution.

/X/ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

- a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

Refer to pages 7a - 7c

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State: Kansas

b. XI

Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

Refer to pages 7a - 7c

TN No. MS-91-41

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

No individual is ineligible by reason of item A.2 if--

- (i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;
- (ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;
- (iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or
- (iv) The agency determines that denial of eligibility would work an undue hardship.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

3. 1902(f) States



Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is \$12,000 or less:

2. If the uncompensated value of the transfer is more than \$12,000:

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State: Kansas

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

I. FOR TRANSFERS OCCURRING PRIOR TO AUGUST 11, 1993:

An institutionalized individual shall not be eligible for medical assistance for coverage of institutional care or HCBS if such individual transferred property for less than fair market value within a 30 month time period prior to or after the date the individual received or was otherwise eligible to receive assistance for such services. For purposes of this section, an institutionalized individual is an applicant or recipient who is residing or is about to reside in a Medicaid-approved institutional or HCBS living arrangement. Institutional care shall be defined as either nursing facility services (ICF or SNF level) or a level of care in a medical institution equivalent to that of nursing facility services. A transfer of property is an act, contract, or lease which partially or totally passes the use, control and/or ownership of property to another person or corporation. Multiple transfers of property that occur within the calendar month shall be treated as a single transfer. In addition, multiple transfers that occur over several months and which effectively reduce the period of ineligibility that would have resulted had the transfers occurred in one month shall be treated as a single transfer.

The following transfers shall not affect eligibility under this provision:

- (1) Transfers which occurred beyond the 30 month time frame listed above;
- (2) A transfer of the institutionalized individual's home to:
 - (a) the spouse of the institutionalized individual;
 - (b) a child of the institutionalized individual who is under the age of 21 or an adult child who meets the blindness or disability criteria of the SSI program;
 - (c) A sibling of the institutionalized individual who has an equity interest in the home and who was residing in the home for a period of at least 1 year immediately before the date the individual entered the institutional or HCBS arrangement; or
 - (d) an adult child of the institutionalized individual other than described in item (b) above who was residing in the home for a period of at least 2 years immediately before the date the individual entered the institutional arrangement and who provided care to the individual which permitted him or her to reside at home rather than in such institutional arrangements.
- (3) Transfers of property that have been approved by the agency;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

- (4) A transfer of property, other than the home, to the institutionalized individual's child, regardless of his or her age, who meets the blindness or disability criteria of the SSI program; and
- (5) A transfer of property, other than the home, to a spouse or to another for the sole benefit of the spouse, if the individual's spouse does not transfer these resources to another person for less than fair market value.

Unless otherwise exempted above, a transfer of real and/or personal property to an irrevocable trust or similar irrevocable legal device shall be considered a transfer without adequate consideration if the principal of the trust is not available except as provided for under section 1902(k) of the Social Security Act. This is due to the fact that the person who created the trust does not retain the right to dissolve or amend the trust for purposes of obtaining the resource. Trusts established for burial purposes such as a \$3000 irrevocable funeral agreement created under K.S.A. 16-303 or trusts used to fund pre-purchased burial merchandise are not affected by this provision. The trust must have been established with the person's own assets and by either the applicant/recipient or by the applicant/recipient's spouse, legal guardian (including a parent), or legal representative.

In determining the uncompensated value of the property, the agency shall: (1) establish the fair market value of the property; (2) determine the equity value in the property (fair market value less encumbrances); and (3) determine the amount of sale price of the property. The uncompensated value shall be the lesser of (1) the difference between the fair market value and the sale price or (2) the equity value.

A period of ineligibility shall be established if full compensation was not received and the client has not established clear and convincing evidence that the transfer was not for the purpose of establishing eligibility. The client shall be given the opportunity to rebut the State's presumption that he or she transferred resources for less than fair market value. The client shall not be ineligible for assistance if such action is necessary to avoid undue hardship. In order to grant hardship, the individual must verify that he or she has exhausted all nonexempt resources to meet living and/or medical expenses, including those amounts protected under the allowable resource levels.

The period of ineligibility for a transfer of property cannot extend longer than 30 months from the date of the transfer. The period of ineligibility shall be established based on the uncompensated value of the transferred property as noted below and shall begin with the month the property was transferred.

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Supersedes TN No. MS-93-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

To determine the period of ineligibility the uncompensated value shall be divided by the average monthly cost to a private patient of nursing facilities in the state. The number of months obtained shall be rounded to the lowest whole month.

If there is evidence that a transfer was made for the purpose of becoming eligible for assistance and the property is later reconveyed to the individual, or if there is an adjustment in the transfer through which full compensation is received, the loss of resource no longer exists and the client may, if otherwise eligible, receive assistance.

The applicant/recipient is responsible for providing clear and convincing evidence that the transfer of property was not for the purpose of establishing eligibility and that the transfer was exclusively for another purpose.

The decision of the agency with respect to convincing evidence shall be governed by the following criteria:

1. A transfer of property shall be considered in the light of the circumstances existing at the time the transfer was made.
2. The longer the interval between the transfer and the application, the more weight should be given to the applicant's statement that the transfer was for another purpose and not connected with the application for assistance.
3. Property transferred to relatives other than as exempted above and personal friends may be assumed to be for the purpose of becoming eligible unless evidence is presented that the transfer occurred exclusively for one of the following reasons: the property transfer was necessary in relation to a change in location or maintenance of a satisfactory standard of living; or the transfer was related to debt payment; or the salvaging of investment prior to foreclosure or failure of business or a business investment to assist the person to be partially or wholly self-supporting; or the transfer was for the purpose of liquidating a resource to provide for living expenses.
4. A transfer of property resulting from the removal of the applicant's or recipient's name from the title shall not affect eligibility providing the client can substantiate that he or she has no ownership interest in the resource, has not contributed to the resource, and that his or her access to the resource is limited to acting as an agent for the other person. This provision is not applicable to property that is held jointly by legally responsible persons.

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Supersedes TN No. MS-92-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

5. In arriving at intent, the uncompensated value must be such that it would be evident to the ordinary individual that full value has not been received and all the circumstances will be considered in each case. It is not expected that all persons will avoid an error in judgment. If there has been considerable fluctuation in property values, the applicant may not have been aware of the full value of the property transferred.

II. FOR TRANSFERS OCCURRING ON OR AFTER AUGUST 11, 1993:

A period of ineligibility shall be established only for institutionalized persons only if full compensation was not received and the client has not established clear and convincing evidence that the transfer was not for the purpose of establishing eligibility. The client shall be given the opportunity to rebut the State's presumption that he or she transferred assets for less than fair market value. The client shall not be ineligible for assistance if such action is necessary to avoid undue hardship. In order to grant hardship, the individual must verify that he or she has exhausted all nonexempt assets to meet living and/or medical expenses, including those amounts protected under the allowable resource levels and his or her health or life would be endangered if deprived of medical care.

The period of ineligibility shall be established based on the uncompensated value of the transferred assets and shall begin with the month the assets were transferred.

To determine the period of ineligibility the uncompensated value shall be divided by the average monthly cost to a private patient of nursing facilities in the state. The number of months obtained shall be rounded to the lowest whole month.

If there is evidence that a transfer was made for the purpose of becoming eligible for assistance and the asset is later reconveyed to the individual, or if there is an adjustment in the transfer through which full compensation is received, the loss of asset no longer exists and the client may, if otherwise eligible, receive assistance.

The applicant/recipient is responsible for providing clear and convincing evidence that the transfer of assets was not for the purpose of establishing eligibility and that the transfer was exclusively for another purpose.

TN No. MS-93-27

Supersedes

TN No. MS-92-19

Approval Date MAR 10 1994

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

The decision of the agency with respect to convincing evidence shall be governed by the following criteria:

1. A transfer of assets shall be considered in the light of the circumstances existing at the time the transfer was made.
2. The longer the interval between the transfer and the application, the more weight should be given to the applicant's statement that the transfer was for another purpose and not connected with the application for assistance.
3. Assets transferred to relatives other than as exempted above and personal friends may be assumed to be for the purpose of becoming eligible unless evidence is presented that the transfer occurred exclusively for one of the following reasons: the asset transfer was necessary in relation to a change in location or maintenance of a satisfactory standard of living; or the transfer was related to debt payment; or the salvaging of investment prior to foreclosure or failure of business or a business investment to assist the person to be partially or wholly self-supporting; or the transfer was for the purpose of liquidating a resource to provide for living expenses.
4. A transfer of assets resulting from the removal of the applicant's or recipient's name from the title shall not affect eligibility providing the client can substantiate that he or she has no ownership interest in the asset, has not contributed to the asset, and that his or her access to the resource is limited to acting as an agent for the other person. This provision is not applicable to assets that are held jointly by legally responsible persons.
5. In arriving at intent, the uncompensated value must be such that it would be evident to the ordinary individual that full value has not been received and all the circumstances will be considered in each case. It is not expected that all persons will avoid an error in judgment. If there has been considerable fluctuation in property values, the applicant may not have been aware of the full value of the assets transferred.

Where a spouse transfers an asset that results in a penalty for the individual, if that spouse is later institutionalized and becomes eligible for Medicaid, the remaining penalty period shall be divided equally between the spouses. If the individual is no longer subject to a penalty (e.g. the individual no longer receives nursing facility services or the individual dies), the remaining period shall be served by the spouse. In no instance will the total period imposed on the couple exceed the length of the penalty originally imposed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

1917(c)

The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

— The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

N/A

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

— The following other long-term care services for which medical assistance is otherwise under the agency plan:

N/A

State: KANSAS

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
- X the first day of the month in which the asset was transferred;
- ___ the first day of the month following the month of transfer.
4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:
- X the average monthly cost to a private patient of nursing facility services in the agency;
- ___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.
5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;
- ___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

N/A

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Supersedes
TN No. ---

State: KANSAS

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

does not impose a penalty;

imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

does not impose a penalty;

imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

totals the value of all assets transferred to produce a single penalty period;

calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

assigns each transfer its own penalty period;

uses the method outlined below:

State: KANSAS

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

- (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

If both spouses are institutionalized at the time the penalty is established, the period of ineligibility which applies is to be split equally (or in the case where the period does not divide evenly, split so that one spouse serves one or more than the other) and each spouse would be ineligible over the same period of time. If the spouse of the individual is institutionalized at a later date, the penalty period which remains as of that time shall be split as indicated previously between both spouses.

- (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

 The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

 For transfers of individual income payments, the agency will impose partial month penalty periods.

 For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

 X The agency uses an alternate method to calculate penalty periods, as described below:

The amount of income transferred each month shall continue to be considered as available income in the post-eligibility process.

State: KANSAS

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

The individual is informed of the hardship criteria noted below and must formally request a hardship determination. Individual is responsible for documenting how the criteria is met.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

The individual must verify that he or she has exhausted all available legal remedies for reclaiming the assets or receiving full compensation and has used all nonexempt resources to meet living and/or medical expenses, including those amounts protected under the allowable resource levels.

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TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Home and community-based services under a 1915(c) or (d) waiver.

JUL 19 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

_____ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

X The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

1905(a)(26)

Program of All-Inclusive Care for the Elderly (PACE)

JUL 19 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

X The State uses the first day of the month in which the assets were transferred

_____ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:
- the average monthly cost to a private patient of nursing facility services in the State at the time of application;
 - the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.
5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;
- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:
6. Penalty period for amounts of transfer less than cost of nursing facility care--
- Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.
 - The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

JUL 19 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

JUL 19 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

- (a) Of medical care such that the individual's health or life would be endangered; or
- (b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

JUL 19 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

_____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed _____ days (may not be greater than 30).

Revision: HCFA-PM-95-1 (MB)

Supplement 10 to Attachment 2.6-A

Page 1

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

The individual must verify that he or she has exhausted all legal remedies for gaining complete access to the principal as well as income of the trust and that all other nonexempt assets have been expended to meet living and medical expenses, including those amounts protected under the allowable resource levels.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is \$5,000.00.*

* Under state law, an irrevocable trust for funeral services cannot exceed \$5,000.00. An irrevocable trust for purpose of pre-purchasing burial merchandise (including plots, spaces, vaults, caskets, etc.) can be established for any amount.

TN #06-16 Approval Date **DEC 13 2006** Effective Date 07/01/06 Supersedes TN #01-20

Revision: HCFA-AT-85-3
FEBRUARY 1985

(BERC)

SUPPLEMENT 11 to ATTACHMENT 2.6-A

State Kansas

LESS RESTRICTIVE METHODOLOGIES FOR TREATMENT OF INCOME AND RESOURCES THAT DIFFER FROM THOSE OF THE SSI PROGRAM (PREVIOUSLY APPROVED ON MARCH 18, 1982 - TN No. MS-81-7).

1. For AFDC-related and aged, blind, and disabled individuals, income-in-kind is excluded from consideration as income for all coverage groups.
2. For aged, blind, and disabled individuals, allowing work expense deduction of \$50 for part-time employment and \$75 for full-time employment to determine countable earned income for institutionalized employed persons.

TN No. MS-85-11
Supersedes
TN No. MS-81-7

Approval Date 10/9/85

Effective Date 10-1-81

Revision: HCFA-PM-97-2
December 1997

SUPPLEMENT 12 TO
ATTACHMENT 2.6-A
Page 1
OMB No.:0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Not Applicable

TN No. _____
Supersedes
TN No. MS-91-11

Approval Date APR 27 1998

Effective Date 1-1-98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

SPOUSAL IMPOVERISHMENT PROVISIONS UNDER SECTION 1924 OF THE ACT
(P.L. 100-360, SECTION 303)

The 90 day/year time periods referred to above can be further extended for good cause. Potential good cause reasons would include legal impediments which may prohibit liquidation of some property or extenuating circumstances beyond the control of either or both spouses that delay transfer activity such as an unexpected illness or hospitalization or ultimately cooperation by a necessary third party (joint property owner, life insurance company, etc.). In such instances, the couple or spouse must continue to try to overcome these obstacles and present evidence of their attempts. The transfer period can then be extended for as long as necessary to complete the division. In instances in which the transfer was not completed due to a legal impediment on a piece of property, once the impediment is overcome and the property becomes available, such property would then be subject to transfer pursuant to the determined community spouse resource allowance.

Resources to be transferred to the community spouse in accordance with his or her resource allowance shall be deemed to have been transferred during the 90 day/1 year transfer period described above. Eligibility could then be approved as early as the month of application if the institutionalized spouse is otherwise eligible.

II. INCOME PROVISIONS

A. Community Spouse Income Allowance - Based on the total nonexempt income of the couple, the community spouse allowance shall be determined as follows:

1. If their combined total nonexempt gross income (or adjusted gross for the self-employed) is \$902 or less per month, the income can be made totally available to the community spouse.
2. If the combined total nonexempt gross income (or adjusted gross for the self-employed) is \$902 or less per month, income sufficient enough to bring the spouse's income up to \$902 per month can be made available. The \$902 protected income level can be increased to a maximum of \$1662 per month if there are excess shelter expenses as defined below.

TN No. MS-91-20

Approval Date JUL 19 1991

Effective
Date 4-1-91

Supersedes
TN No. MS-91-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

SPOUSAL IMPOVERISHMENT PROVISIONS UNDER SECTION 1924 OF THE ACT
P.L. 100-360, SECTION 303)

If the applicant's/recipient's spouse has excess shelter expenses, the amount of the allowance can be increased such that the spouse has up to \$1662 per month. Excess shelter expenses are defined in the law as the amount by which the spouse's monthly expense for rent or mortgage payment, including principal, interest, taxes, and insurance (or in the case of a condominium or cooperative, monthly maintenance charges) when added to the Food Stamp standard utility allowance (SUA) exceeds 30% of the previously mentioned \$902 division cap (i.e. \$270). In instances in which utilities are included in the rental payment, the full rental payment shall still be used in computing the excess shelter allowance.

As the standard utility allowance is \$175/month, the amount of the excess shelter allowance would equal the amount by which the spouse's shelter payment exceeds \$95/month. This allowance would be added to the base \$902 allocation amount and, therefore, increase the amount of income the spouse could receive. The amount of the excess shelter allowance cannot exceed \$760/month for a total allocation cap of \$1662 (\$902 base and \$760 excess shelter). Thus, if the spouse's shelter payment equals or exceeds \$855/month, all that can be provided for excess shelter is \$760. Any payment less than \$855 but greater than \$95 would produce a varying allowance.

- B. Dependent Family Member Income Allowance - Each dependent family member who lives with the community spouse can receive \$300 per month of the income of the institutionalized spouse as long as that member's gross monthly income does not exceed the minimum community spouse income allowance standard references above. If the income is in excess of this standard, no income allowance can be provided to that member.

A family member is defined as a child, parent, or brother or sister of either spouse. Dependency may be of any kind (e.g. legal, financial, medical, etc.). The spouse's or dependent member's allegation shall be accepted without challenge unless there is a reason to question it.

- C. Increase to Community Spouse Allowance Based on Financial Duress - A fair hearings officer may increase the amount of the community spouse income allowance if either spouse establishes that a greater allowance

TN No. MS-91-20

Approval Date JUL 19 1991

Effective Date 4-1-91

Supersedes

TN No. MS-91-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE KANSAS

SPOUSAL IMPOVERISHMENT PROVISIONS UNDER SECTION 1924 OF THE ACT
(P.L. 100-360, SECTION 303)

is necessary due to exceptional circumstances resulting in significant financial duress. These circumstances shall be defined as expenses which are unforeseen or which are ongoing and are reasonable and necessary for the health, safety, and/or well-being of the community spouse. An additional allowance would only be provided to the extent that the originally determined community spouse income allowance is inadequate to cover the expenses. Expenses which could result in significant financial duress would include costs associated with prescribed special diet foods or supplements, costs of medical, remedial, or other support services necessary for community spouses to maintain themselves in the community, cost of repairs which are necessary to maintain the home in a livable condition, and other costs associated with unforeseen circumstances such as a fire or flood which result in loss of housing, clothing, household goods, or other necessities. Substantiating documentation will be necessary. Financial duress could not be claimed for usual increases in the cost of rent, food, housing, or clothing.

If a finding of financial duress is made, the hearings officer will establish a new community spouse income allowance sufficient to cover such expenses and specify whether the condition is temporary or will be continuing. If temporary, the hearing officer will establish the duration of the additional allowance and advise the client that if the circumstances continue, he or she may request an extension through the fair hearings process. If continuing, the circumstances shall be reviewed on an annual basis at the time of redetermination. In addition, the community spouse is responsible for notifying the agency at any time should the circumstances change. When the exceptional circumstances no longer exist, the community spouse allowance is to be readjusted.

TN No. MS-89-33

Approval Date 11/18/90

Effective Date 10-1-89

Supersedes

TN No. MS-89-12

Revision: HCFA-PM-91-8 (MB)
October 1991

SUPPLEMENT 13 TO ATTACHMENT 2.6-A
Page 1
OMB No.:

State/Territory: Kansas

Citation

Condition or Requirement

**COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES**

1902(u) of the
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

The methodology as described in SMM section 3598.

Another cost-effective methodology as described below.

Not applicable.

TN No. MS-91-46

Supersedes

TN No. Nothing

Approval Date JAN 30 1992

Effective Date 10/01/91

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

RESOURCE EXEMPTIONS AND TREATMENT OF RESOURCE METHODOLOGIES WHICH ARE MORE LIBERAL THAN THOSE OF THE AFDC OR SSI PROGRAM (APPLICABLE TO ONLY OPTIONAL CATEGORICALLY NEEDY AND MEDICALLY NEEDY)

I. More liberal resource exemptions

- o For the aged, blind, and disabled, if a person enters an institutional living arrangement for long term care, the home shall retain its exempt status for 3 months (including the month of entrance) provided the person does not intend to return to the home and there is no spouse or other dependent family member who continues to live in the home. This provision is in addition to the home exemption policies of the SSI program.
- o For AFDC-related and aged, blind, and disabled individuals, personal effects and keepsakes and household equipment and furnishings are exempt without regard to value.
- o For aged, blind, and disabled individuals, one car is exempt regardless of value. Additional vehicles may be exempt if shown to be essential for employment or self-support, for medical treatment, or if specially equipped for use by a handicapped person.

II. More liberal methodologies for treatment of resources

- o For aged, blind, and disabled individuals, if an individual owns excess nonexempt real or personal property (other than liquid cash assets), assistance can be provided up to 9 months while the individual is making a bona fide effort to dispose of the property.
- o For aged, blind, and disabled individuals, resource value shall be viewed throughout the month and if the individual is resource eligible for 1 day in the month, he or she is eligible for the entire month.
- o For AFDC-related and aged, blind, and disabled individuals, resources that an individual owns jointly with a non-legally responsible person shall not be considered if the individual can demonstrate that he or she has no ownership interest in the resource, has not contributed to the resource, and that his or her access to the resource is limited to acting as an agent for the other person. It is not a requirement that the individual also remove his or her name from the title for the resource to not be considered.

TN No. MS-91-20

Approval Date JUL 19 1991

Effective Date 4-1-91

Supersedes

TN No. MS-88-41

(MB)

SUPPLEMENT 15 TO ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

X Pregnant women with no other eligible children.

X AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

 In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, without modification.

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.

 The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

 The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

 The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

(MB)

SUPPLEMENT 15 TO ATTACHMENT 2.6-A
Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

X

The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

1. The resources of all members of the medical assistance plan are exempt.
2. Lump sum payments are excluded as income.
3. Interest income, which does not exceed \$50.00 a month, is exempt.
4. All interest earned on an IDA account funded under the Assets for Independence Act is excluded from income.
5. The earnings of a child are exempt without time.
6. For individuals who have received Medicaid under this section in one of the four preceding months, \$90.00 of earnings plus 40% of the remaining earnings will be disregarded without a time limit.
7. For self-employed individuals, an adjusted gross income amount must be determined by deducting a standard income producing cost deduction of 25% of the gross earnings. However, the individual has the option of taking the standard 25% reduction or using actual income producing costs as a deduction from gross earnings in place of the standard deduction.
8. All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are exempt.
9. For purposes of the 185% test, disregard all income in excess of 185%.
10. The first \$50.00 per month of irregular, occasional or unpredictable gift income is exempt.

Substitute per letter dated 11/19/01 ^W

(MB)

SUPPLEMENT 15 TO ATTACHMENT 2.6-A
Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

1. The resources of all members of the medical assistance plan are countable.
2. Lump sum payments are countable as income in the month of receipt and for future months based on dividing the payment amount by the monthly budgetary deficit to determine the number of countable months.
3. Interest income is countable in full.
4. Earnings received by a child from a youth program funded by JTAP are exempt for six (6) months.

Earnings of a child who is a full-time student or a part-time student, but not a full-time employee, are exempt except that for determining eligibility under the 185% income limit, the earnings shall only be exempt for six (6) months.

5. Earnings disregard of 1/3 following deduction of \$90.00 work expense and additional \$30.00 disregard.
6. For self-employed persons, actual costs of producing income are allowable deductions from gross earnings.
7. Wages resulting from temporary Census employment are countable.
8. All income is considered for the purposes of 185% test.
9. Gift income up to \$25.00 a month is exempt.

_____ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

_____ The agency continues to apply the following waivers of provisions of part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

TN #MS #01-17 Approval Date NOV 30 2001 Effective Date 07/01/01 Supersedes MS #99-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: KANSAS

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH
SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

\$500,0000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is _____.

This higher standard applies statewide.

This higher standard does not apply statewide. It only applies in the following areas of the State:

This higher standard applies to all eligibility groups.

This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

ATTACHMENT 2.6-B

Standards for Optional State Supplementary Payments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Kansas

14-3

STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

- I. Aged, blind, and disabled recipients of optional State supplementary payments are eligible for medical assistance as categorically needy under this plan. The payments meet the four conditions specified in 45 CFR 248.2(d), that is, they are:
 - A. Regular, in cash, and based on need;
 - B. Available on a Statewide basis;
 - C. Made to reasonable classifications of individuals who, except for the level of their income, would be eligible for an SSI payment, as described in the supplement to this ATTACHMENT; and
 - D. Equal to the difference between income and the financial standard used to determine eligibility for the supplement.

II. There are variations in the payment levels by political subdivisions.

No.

Yes, as described below:

Not applicable - Kansas does not have an optionable supplementary payments program

Sto. Kan Tr. 12/30/74 Incorp. 2/4/75 effective 8/20/74

SUPPLEMENT TO ATTACHMENT 2.6-B - FEDERALLY ADMINISTERED OPTIONAL STATE
 SUPPLEMENT: PAYMENT GROUPS; INCOME LEVELS

2

(Model A)

State Kansas

77-4

NOT APPLICABLE

Payment Category	Income Levels			
	Individual		Couple	
	Gross (2)	Net (3)	Gross (4)	Net (5)
(1)				
<u>AGED</u>				
Living independently	\$400		\$420	
In Nursing Home				
In Foster Home				
With Ineligible Spouse in Household of Another				
Congregate Care Level I Area A				
Area B				
Level II				
In Licensed Mini-Home				
<u>BLIND</u> (Give similar breakdown)				
<u>DISABLED</u>				

ca Ken Tr. 0/24/77 Incorp. 8/19/77 Effective 7/1/77

91
 4
 E

✓ SUPPLEMENT TO ATTACHMENT 2.6-B - STATE-ADMINISTERED OPTIONAL STATE SUPPLEMENT; PAYMENT GROUPS; INCOME LEVELS; ADDITIONAL DISREGARDS; ADDITIONAL ELIGIBILITY CRITERIA

(Total 3)

State: Kansas

NOT APPLICABLE

Payment Category	Income Levels				Additional Disregards	More restrictive eligibility criteria
	Individual		Couple			
(1)	Gross	Net	Gross	Net	(6)	(7)
DISABED						
Living independently	\$400		\$420		\$5 in gifts	Must be age 18 or over
In foster home						
In nursing home - would receive supp. payment under diff. payment category if outside fac.						
In nursing home - no State supp. payment program						
In nursing home - would not receive supp. payment if outside fac. because income exceeds SSI or State supp. payment level						
(Give similar breakdown other categories)						

ATTACHMENT 2.6-C

Eligibility Conditions and Requirements for the Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

74-13

State Kansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS FOR THE MEDICALLY NEEDY

OFFICIAL

I. Non-financial eligibility

For families and children, and aged, blind, and disabled individuals, the non-financial eligibility conditions are the same as those applicable to the categorically needy as described in Section II of ATTACHMENT 2.6-A, except with respect to blind and disabled individuals as described in Section C of ATTACHMENT 2.2-A.

II. Financial eligibility

A. Treatment of income

1. Income levels by family size

a. The minimum net income level for maintenance is as described below and as indicated in the table below:

i. The higher of the payment standards generally used as a measure of financial eligibility in the money payment programs, as specified in 45 CFR 248.3(c)(1)(ii).

This level does not exceed 133 1/3 percent of the highest amount ordinarily paid to an AFDC family of comparable size, as specified in 45 CFR 248.4(b)(4).

This level exceeds 133 1/3 percent of the highest amount ordinarily paid to an AFDC family of comparable size, as specified in 45 CFR 248.4(b)(4). The State agency has methods for excluding from its claim for Federal financial participation payments of amounts equivalent to those in columns (3) and (5) in the table below.

St. Kans Ir. 12/30/74 Incorp. 2/4/75 Effective 8/20/74

State Kansas

74-3

ii. A level higher than that specified in Item i above.

This level does not exceed 133 1/3 percent of the highest amount ordinarily paid to an AFDC family of comparable size, as specified in 45 CFR 248.4(b)(4).

This level exceeds 133 1/3 percent of the highest amount ordinarily paid to an AFDC family of comparable size, as specified in 45 CFR 248.4(b)(4). The State agency has methods for excluding from its claim for Federal financial participation payments of amounts equivalent to those in columns (3) and (5) in the table below.

iii. A level lower than that specified in Item i above, but no lower than 133 1/3 percent of the highest amount ordinarily paid to an AFDC family of comparable size, as specified in 45 CFR 248.4(b)(4).

b. The State agency uses urban and rural differentials in establishing the amounts of net income protected for maintenance.

Yes. These amounts are indicated in columns (2) and (4) of the table below.

No. The net income levels for all medically needy individuals are as stated in column 2 of the table below.

St. Kans To 12/31/74 from 2/7/75 effective 7/31/74

State KANSAS

80-16

The income levels for the medically needy are specified below:

Family Size	Net income level protected for maintenance <input type="checkbox"/> urban only <input checked="" type="checkbox"/> urban & rural	Amount by which Column (2) exceeds limits specified in 45 CFR 248.4	Net income level for persons living in rural areas	Amount by which Column (4) exceeds limits specified in 45 CFR 248.4
(1)	(2) *	(3)	(4)	(5)
1	\$ 310	\$ NONE	\$	\$
2	\$ 390	\$ "	\$	\$
3	\$ 400	\$ "	\$	\$
4	\$ 410	\$ "	\$	\$
5	\$ 450	\$ "	\$	\$
6	\$ 490	\$ "	\$	\$
7	\$ 520	\$ "	\$	\$
	\$ 550	\$ "	\$	\$
	\$ 590	\$ "	\$	\$
	\$ 630	\$ "	\$	\$
for each additional person in:	\$ 40	\$	\$	\$

* per month

Note: During period from July 1 through September 30, 1980 the net income level protected for maintenance for a two person family size was \$360.

ms 80-16
ST. KS SA APPROVED 11/20/80
Effective 10/1/80
RD Approved 3/12/81

74-3

State Kansas

2. Income disregards

a. In determining net income for families and children, the disregards and set-asides and exemption of work-related expenses in the State's approved AFDC plan are applied.

b. In determining net income for aged individuals, the following disregards are applied:

The disregards of the SSI program.

The disregards of the State supplementary payment program.

The disregards of the SSI program, except for the restrictions specified in section II-B-1 of ATTACHMENT 2.6-A.

c. In determining net income for blind individuals, the following disregards are applied:

The disregards of the SSI program.

The disregards of the State supplementary payment program

The disregards of the SSI program, except for the restrictions specified in section II-B-2 of ATTACHMENT 2.6-A.

d. In determining net income for disabled individuals, the following disregards are applied:

The disregards of the SSI program.

The disregards of the State supplementary payment program

The disregards of the SSI program, except for the restrictions specified in section II-B-3 of ATTACHMENT 2.6-A.

ms 74-3

St. Kans Tr. 12/31/74 Incorp. 3/4/75 Effective 8/20/74

State KANSAS

81-2

3. Handling of Excess Income

a. Income in excess of the amount protected for maintenance, as specified in the table on page 3 of this ATTACHMENT, is considered as available for payment of medical care and services. The State agency measures available income for the following period to determine the amount of excess income applicable to the cost of medical care and services:

Six months.

b. Excess income may be applied to medical and remedial care and services not encompassed in the plan:

Without limitation or exceptions

With the exception of the care and services specified below:

Any item or service not considered medically necessary. Medical necessity is defined as an item or service prescribed or provided by a physician or other medical practitioner for a specific medical condition for the purpose of achieving a specific result. Specific exclusions are sex change operations, cosmetic surgery reversal, sterilization, acupuncture, mattresses, seeing eye dog, air conditioner humidifiers, de-humidifiers, waterbeds, food scales, weight scales, blenders, sunglasses, heat lamps, vaporizers, heating pads, and exercise bikes.

B. Treatment of resources

1. The resource levels:

Are the same as the level specified in the State's approved AFDC plan or the SSI program, whichever is higher for a family of a particular size.

Exceed the level specified in the State's approved AFDC plan or the SSI program, whichever is higher for a family of a particular size.

A supplement to this ATTACHMENT describes the limitations imposed on resources for the medically needy.

Table I-M

Persons in Plan	1	2	3	4	Each Add'l Person
Amount Allowed	\$1,800	\$2,400	\$2,800	\$3,200	\$200

MS 81-2
ST. KS SA Approved 2/19/81
RC Approved Effective 3/1/81

OFFICIAL

September 1980

5a
80-16

Table II-M

INCOME PROTECTED TO MEET MAINTENANCE NEEDS

Persons in Independent Living

Person In Long Term Care	Number of Months							
		1	2	3	4	5	6	7
\$ 25	1 mo.	\$ 310	\$ 390	\$ 400	\$ 410	\$ 450	\$ 490	\$ 520
50	2 mos.	620	780	800	820	900	980	1040
75	3 mos.	930	1170	1200	1230	1350	1470	1560
100	4 mos.	1240	1560	1600	1640	1800	1960	2080
125	5 mos.	1550	1950	2000	2050	2250	2450	2600
150	6 mos.	1860	2340	2400	2460	2700	2940	3120
300	12 mos.	3720	4680	4800	4920	5400	5880	6240

The protected income level for 8 persons and above is the basic standard for public assistance for the same number of persons plus the maximum state shelter standard.

ST. KS SA APPROVED 11/20/80
Effective 10/1/80
RD APPROVED 3/12/81

OFFICIAL

80-16

Revision: HCFA-AT-80- 58
August, 1980

Attachment 2.6-C
Page 6

State KANSAS

2. The method(s) checked below is used in handling resources in excess of those specified above:

- Excess non-income producing property (except the home) must be disposed of
- Any excess resources render the individual ineligible
- Other, described as follows:

ST. Ks SA Approved 11/20/80
Effective 10/1/80 RO Approved 3/12/81

ATTACHMENT 3.1-A

**Medical and Remedial Care and Services
—Amount, Duration and Scope**

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: No limitations With limitations*

2.a. Outpatient hospital services.

Provided: No limitations With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

Provided: No limitations With limitations*

Not provided.

Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: No limitations With limitations*

3. Other laboratory and x-ray services.

Provided: No limitations With limitations*

*Description provided on attachment.

TN No. MS-92-08
Supersedes
TY MS-91-41

Approval Date MAY 22 1992

Effective Date JAN 01 1992

HCFA ID: 7986E

State/Territory: Kansas

**AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Provided: No limitations With limitations*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. *
- c. Family planning services and supplies for individuals of childbearing age.
- Provided: No limitations With limitations*
5. a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.
- Provided: No limitations With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
- Provided: No limitations With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' Services
- Provided: No limitations With limitations*

*Description provided on attachment.

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

[X] Provided: No limitations [X] With limitations*
Not provided.

c. Chiropractors' services.

[] Provided: No limitations [] With limitations*
[X] Not provided.

d. Other practitioners' services.

Provided: Identified on attached sheet with description of limitations, if any.
 Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: No limitations With limitations*

b. Home health aide services provided by a home health agency.

Provided: No limitations With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

No limitations With limitations*

*Description provided on attachment.

TN No. 03-17 Supersedes MS 02-30 Approval Date 07-11-03 Effective Date 07/01/03

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided: No limitations With limitations*

Not provided.

8. Private duty nursing services.

Provided: No limitations With limitations*

Not provided.

*Description provided on attachment.

TN No. MS-91-41 Approval Date Effective Date
Supersedes
TN No. MS-85-15 HCFA ID: 7986E

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services. *440.90*
 Provided: No limitations With limitations*
 Not provided.

10. Dental services. *440.100*
 Provided: No limitations With limitations*
 Not provided.

11. Physical therapy and related services. *440.110*
a. Physical therapy.
 Provided: No limitations With limitations*
 Not provided.

b. Occupational therapy.
 Provided: No limitations With limitations*
 Not provided.

c. Services for individuals with speech, hearing, and language disorders
(provided by or under the supervision of a speech pathologist or
audiologist).
 Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN No. MS-85-39
Supersedes
TN No. 77-4

Approval Date

Aug. 22, 85

Effective Date

7/1/85

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12: Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided: No limitations With limitations*
 Not provided.

b. Dentures.

Provided: No limitations With limitations*
 Not provided.

c. Prosthetic devices.

Provided: No limitations With limitations*
 Not provided.

d. Eyeglasses.

Provided: No limitations With limitations*
 Not provided.

13.. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN No. MS-85-40
Supersedes
TN No. _____

Approval Date

8/22/85

Effective Date

7/1/85

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- b. Screening services
[] Provided: [] No limitations [] With limitations*
[X] Not provided.
- c. Preventive services
[] Provided: [] No limitations [] With limitations*
[X] Not provided.
- d. Rehabilitative services.
[X] Provided: [] No limitations [X] With limitations*
[] Not provided.
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
[X] Provided: [] No limitations [X] With limitations*
[] Not provided.
- b. Skilled nursing facility services.
[X] Provided: [] No limitations [X] With limitations*
[] Not provided.
- c. Intermediate care facility services.
[X] Provided: [] No limitations [X] With limitations*
[] Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 15.a. ¹⁵⁰ Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
- Provided: No limitations With limitations*
 Not provided.
- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
- Provided: No limitations With limitations*
 Not provided.
16. ¹⁵⁰ Inpatient psychiatric facility services for individuals under 22 years of age.
- Provided: No limitations With limitations*
 Not provided.
17. ^{150 165} Nurse-midwife services.
- Provided: No limitations With limitations*
 Not provided.
18. Hospice care (in accordance with section 1905(o) of the Act).
- Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a) (19) or section 1915(g) of the Act).

Provided: With limitations

Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

Provided: With limitations*

Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a eligible provider (in accordance with section 1920 of the Act).

Provided: No limitations With limitations*

Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided: No limitations With limitations*

Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: No limitations With limitations*

*Description provided on attachment.

FN No. MS-92-08
Supersedes Approval Date MAY 22 1992 Effective Date JAN 01 1992
FN No. MS-91-41
HCFA ID: 7986E

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

Provided: No limitations With limitations*

Not provided.

b. Services of Christian Science nurses.

Provided: No limitations With limitations*

Not provided.

c. Care and services provided in Christian Science sanatoria.

Provided: No limitations With limitations*

Not provided.

d. Nursing facility services for patients under 21 years of age.

Provided: No limitations With limitations*

Not provided.

e. Emergency hospital services.

Provided: No limitations With limitations*

Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Provided: No limitations With limitations*

Not provided.

*Description provided on attachment.

TN No. MS-91-41
Supersedes MS-87-25 Approval Date JAN 27 1992 Effective Date OCT 01 1991

HCFA ID: 7986E

Substitute per letter dated 8/4/98

Revision: HCFA-PM-94-9 (MB)
December 1994

ATTACHMENT 3.1-A
Page 10

State: Kansas

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

___ provided: ___ State Approved (Not Physician) Service Plan Allowed
 ___ Services Outside the Home Also Allowed
 ___ Limitations Described on Attachment

X not provided

27. Early Intervention Services to Children

These services are provided to children from birth to age 3 and children in transition to pre-school up to age 4 who meet one of the Developmental Delay eligibility categories set forth in the federal regulations promulgated under Part C of the Individuals with Disabilities Education Act (IDEA). These services are in addition to other medically necessary Early and Periodic Screening, Diagnosis and Treatment services otherwise included in the State Plan.

X provided _____ not provided

AUG 14 1998

TN#MS-97-17 Approval Date _____ Effective Date 7-1-97 Supersedes TN#MS-95-01

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
Page 11

State of Kansas
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

28. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

 X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A General Limitations

3.1-A Limitation

General Limitations

1. Prior authorization is required for out-of-state care with the exception of emergency care, services provided within 50 miles of the state border, and services provided to children in the care, custody, and control of the Department of Social and Rehabilitation Services.

Exceptions: Nursing facilities, intermediate care facilities, community mental health centers, partial hospitalization providers and alcohol and drug program providers are considered out-of-state if they are physically beyond the border even if less than 50 miles.

2. Cosmetic, pioneering, and experimental services and related services are not covered. Such services are defined by the Division of Medical Services.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A

#1

Page 1

Inpatient Hospital Services Limitations

1. Services shall be ordered by a physician and shall be related specifically to the present diagnosis of the Consumer.
2. Rehabilitation therapy is limited to that which is restorative in nature and provided following physical debilitation due to acute physical trauma or physical illness.
3. Prosthetic devices provided by a hospital are limited to those that replace all or part of an internal body organ, including replacement of these devices.
4. Elective surgery is noncovered with the exception of elective sterilization procedures.
5. Transplant surgery is limited to corneal, kidney, bone marrow, pancreas and liver transplants and related services. Procurement of the organ is covered.
6. Inpatient acute care related to psychiatric services is limited to stays in which the psychiatric plan of care is directed by a psychiatrist and in which psychotherapy is provided on a daily basis. Individuals admitted to psychiatric care must have received an assessment to determine appropriate care level before services are reimbursed.
7. Sterilization and abortions are covered in accordance with current federal regulation.
8. Discharge days are noncovered.
9. Long-Term Head Injury Rehabilitation Services:

Services include, but are not limited to, inpatient restorative and rehabilitative therapies designed to prevent physical or mental deterioration, achieve and maintain maximum use of physical or cognitive capabilities and health, and/or restore and retain self-help and adaptive skills necessary to achieve the recipient's discharge from inpatient status at the earliest possible time

These programs are intended to provide active treatment for the purpose of relearning independent living skills for those individuals who have experienced a Traumatic Brain Injury (TBI) and choose to receive services in a Traumatic Brain Injury Rehabilitation Facility. "Active Treatment" is defined as an aggressive and organized effort to fulfill each person's optimal functional capacity.

TN # 06-09 Approval Date MAR - 7 2007 Effective Date JUL - 1 2007 ~~01/01/07~~ Supersedes TN 03-04

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A

#1

Page 2

Recipients of these services must be assessed prior to admission and once admitted must be re-assessed for the need of continued services on a regularly scheduled basis as defined by state law, regulation, and/or policy. Services must be provided in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals and measurable, behaviorally-stated objectives.

The need for services is evidenced by:

- The recipient has a diagnosis of Traumatic Brain Injury, defined as a traumatically-acquired, non-degenerative, structural brain injury resulting in residual deficits and disability;
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- The individual with TBI requires the provision of services in an institutional setting because of the intensity, duration, or frequency of the need for the services, the lack of appropriate community services to meet those needs, or both.

Service furnished in a Long-Term Head Injury Rehabilitation Facility must satisfy all requirements of subpart G of 42 CFR 483 governing the use of restraint and seclusion.

Provider Qualifications: A Long-Term Head Injury Rehabilitation Facility must meet the requirements and standards of state certification or licensure, and national accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

Services must be furnished by or under the direction of a physician and all staff must meet applicable licensure and certification requirements and adhere to scope of practice definitions of licensure boards.

MAR - 7 2007

JUL - 1 2007

TN # 06-09 Approval Date _____ Effective Date 01/01/07 Supersedes TN New

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#2.a.

Outpatient Hospital Services Limitations

1. Non-emergency services are covered. Outpatient hospital assessment of the need for emergency service is non-covered.
2. Emergency services are covered.
3. Elective surgery is non-covered with the exception of elective sterilization procedures.
4. Partial hospitalization for psychiatric illness is limited to programs which have been licensed by SRS (Social and Rehabilitation Services).
5. Sterilization and abortions are covered in accordance with current federal regulations.
6. Rehabilitation therapy is limited to that which is restorative in nature and provided following physical debilitation due to acute physical trauma or physical illness. Therapy services must be prescribed by the attending physician. Therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for participants from birth through age 20.
7. Prosthetic devices provided by a hospital are limited to those that replace all or part of an internal body organ, including replacement of these devices.
8. Ambulance services billed as outpatient services are non-covered.
9. See Attachment 3.1-A, #4.b. for outpatient hospital service limitations for children from birth through age 20.

KANSAS MEDICAID STATE PLAN

Attachment 3.1A
#2b

3.1-A Limitation

#2b Rural Health Clinic Services

Refer to limitations described in Attachment 3.1-A

#5 Physician Services with the exception of limitations on physician extender services. These services are not limited in Rural Health Clinics.

#7c Home Health Services

Refer also to General Limitations page.

State Plan

Trans. No. MS-83-8

Submitted 6-29-83

Approved 8-26-83

"Substitute per letter dated 7/18/90"

Substituted Page July 17, 1990.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#2.c.

Limitations of Federally Qualified Health Centers

Federally qualified health center services are subject to the limitations in effect in Chapter 42 U.S.C., Section 1905 (a) (2) (C). For other ambulatory services the limitations set for these services elsewhere in the Kansas Medicaid State Plan are applicable.

TN/MS-90-20 App Date MAR 15 1991 Eff Date APR 01 1992 Supersedes nothing

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#3

Other Laboratory and X-Ray Services Limitations

Computerized axial tomography (CAT) scans are limited to those performed for diagnostic purposes.

Premarital blood tests are noncovered.

Paternal blood tests are noncovered.

Transportation of specimens is noncovered.

Catheterization for collection of specimens for adult care home recipients is noncovered.

**Early and Periodic Screening Diagnosis and Treatment Limitations
“Kan-Be-Healthy”**

Additional services above the limitations listed in the State Plan for an EPSDT participant are covered if the participant meets the medical necessity and has received prior authorization or pre-determination for the additional services.

Non-Covered procedures are covered for EPSDT participants if the State determines the services to be medically necessary and the non-covered procedures are prior authorized.

- **Kan Be Healthy Screening**

Description:

- i. A comprehensive screening at specific intervals which includes: a comprehensive health and developmental history (including assessment of both physical and mental health development), a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, vision screening, hearing screen, dental screen, nutrition screen, other tests as medically necessary, and referrals for treatment.
- ii. An inter-periodic screening for any of the above or other suspected physical, mental, developmental, vision, or hearing deficits, which is medically necessary to determine the existence of suspected illnesses or conditions.

Qualifications:

- i. A practitioner, facility, or agency licensed in the State of Kansas to evaluate, diagnose, or treat an individual’s physical, mental, or developmental deficits/illnesses/conditions.
- ii. A Registered Nurse licensed in the State of Kansas and who has been trained and has certification to complete Kan Be Healthy Screenings.
- iii. Professionals with the qualifications listed in (i and ii) employed by local education agencies for services to children listed on either the child’s Individual Education Plan (IEP) or the child’s Individual Family Service Plan (IFSP).

Units of Service: Per Screen

Additional services available to children are listed below. Those services which include procedures requiring prior authorization are noted with an asterisk*:

- **Clinic Services**
 - Elective Surgery is covered at ambulatory surgical centers.*

- **Dental Services (including Medical and Surgical Services Furnished by a Dentist)***
 - Covered dental services including cleanings twice per year, fluoride treatments three times per year, fillings, pulpotomies, extractions, x-rays, dentures, endodontia, and orthodontia. Partial dentures, repair and adjustments are covered. Additional services are covered by prior authorization.

- **Equipment and Supplies**
 - Wheelchair purchases, rentals and accessories may be covered with prior authorization.

- **Eyeglasses**
 - Lenses and frames for eyeglasses replacement is covered up to three times per year. Additional lenses and frames are covered by prior authorization for vision changes.
 - Contact Lenses and certain tints require prior authorization.

- **Home Health Nursing Services**
 - Respiratory therapy is covered.

- **Immunizations**
 - Age appropriate immunizations as determined by American Committee on Immunization Practices (ACIP)

- **Inpatient Hospital Services**
 - Elective Surgery is covered.*

- **Optometric Services**
 - Eye exams, refractions and coordination testing are covered.

- **Other Practitioners'**
 - Dietitian Services are covered.

- **Outpatient Hospital Services**
 - Elective Surgery is covered.*

- **Podiatric Services**
 - Podiatry services are covered.

- **Positive Behavioral Support Services***

- One Environmental Assessment per one year billing cycle.
- Sixty Hours of PBS Treatment per one year billing cycle.
- One Person Centered Planning session per one year billing cycle.
- Qualifications: Individuals providing PBS services must have, at a minimum, a bachelor's degree and have completed the Kansas Institute for Positive Behavior Support (KIPBS) Training Program.

(All services approved by the KIPBS prior authorization system as part of an exception will constitute a new service arrangement for a beneficiary with specific limitations and conditions. Any services beyond these limitations must be based on medical necessity and must receive prior authorization using the process noted above.)

- **Prescribed Drugs**

- Antihistamines, cold and cough medicines and vitamins are covered.

- **Transportation Services**

- Non-emergent transportation is covered* for medical visits.
- Subsistence (food and lodging)* may be covered for KBH participants and one attendant under certain circumstances.

*Those services which include procedures requiring prior authorization are noted with an asterisk.

**Early and Periodic Screening Diagnosis and Treatment Limitations
“Kan Be Healthy ” School Based Services**

• **School Based Services**

- Services to children listed on either the child’s Individual Education Plan (IEP) or the child’s Individual Family Service Plan (IFSP) including:

Health Screening:

- a. Description: An evaluation of a child that may include but is not limited to, developmental, psychological, speech and language, occupational and physical therapy assessment.
- b. Qualifications: A practitioner, facility, or agency licensed in the State of Kansas to evaluate, diagnose, or treat an individual’s physical, mental, or developmental deficits/illnesses/conditions. A Registered Nurse licensed in the State of Kansas and who has been trained and has certification to complete Kan Be Healthy Screenings. Professionals with the qualifications noted above that are employed by local education agencies to provide services to children listed on either the child’s Individual Education Plan (IEP) or the child’s Individual Family Service Plan (IFSP). All services must be provided in accordance with 42 CFR 440.60.

Medical Transportation:

- a. Description: Transportation of a child to sites of medically appropriate and necessary services. Including transportation of a caretaker or attendant when medically necessary.
- b. Qualifications: Services must be provided by an enrolled transportation provider within the guidelines described in the Kansas Medical Assistance Program medical benefits brochure and the Kansas Medical Assistance Provider manual.
- c. Limitations: Transportation is covered only when it is necessary to receive another Medicaid service, and the need for both the Medicaid service and the transportation are specified in the IEP/IFSP. Similar transportation would be required if the child was not in a school setting.

**Early and Periodic Screening Diagnosis and Treatment Limitations
“Kan Be Healthy” School Based Services (continued)**

Nursing Services:

- a. Description: Nursing services include but are not limited to initial and ongoing assessments, communications with physicians, medication set-up and administration, invasive procedures, treatment and evaluation of wounds, individualized teaching of care procedures and other services designed to provide for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. All services must be provided in accordance with 42 CFR 440.60 and 42 CFR 440.130(d).
- b. Licensed Registered Nurse or Licensed Practical Nurse.

Occupational Therapy:

- a. Description: Therapy designed to correct deficits or delays, provided in accordance with 42 CFR 440.110.
- b. Qualifications: Professionals licensed by the Board of Healing Arts, provided in accordance with 42 CFR 440.110.

Physical Therapy:

- a. Description: Therapy designed to correct deficits or delays, provided in accordance with 42 CFR 440.110.
- b. Qualifications: Professionals licensed by the Board of Healing Arts, provided in accordance with 42 CFR 440.110.

Speech, Language and Hearing:

- a. Description: Therapy designed to correct deficits or delays, provided in accordance with 42 CFR 440.110.
- b. Qualifications: Professionals licensed by the Board of Healing Arts, provided in accordance with 42 CFR 440.110.

Vision Services:

- a. Description: An evaluation of a child’s vision status, the making of referrals for medical or other attention.
- b. Qualifications: Registered Nurse certified by the Kansas Department of Health and Environment.

MAY 30 2007

TN # 06-08 Approval Date _____ Effective Date 07/01/07 Supersedes New

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A

#4.c

Page 1

Family Planning Services Limitations

1. Family planning services provided by physicians have no limitations.
2. Family planning services provided in health departments are limited to one initial visit per consumer, one annual visit per year and interim visits as needed.

Physicians' Services Limitations

Visits

1. Office visits are not covered when the only service provided is an injection or some other service for which a charge is usually not made.
2. Hospital visits are limited to one per day of Medicaid-covered stay per consumer.
3. Nursing facility visits are limited to one per month per consumer unless there is a medical necessity for more.
4. See Attachment 3.1-A, #4.b. for physician visit service limitations for children under 21 years of age.

Consultations

1. Consultations without a written report are noncovered.
2. Inpatient hospital consultations are limited to one per ten day period unless there is medical necessity for more.
3. Other consultations are limited to one per condition every 60 days unless there is medical necessity for more.

Surgery

1. Only medically necessary surgical procedures are covered with the exception of sterilizations.
2. Abortions, family planning services and sterilizations are covered in accordance with current federal regulations. Reverse sterilizations are noncovered.
3. Experimental, pioneering and cosmetic surgeries are noncovered.
4. Transplant surgery is limited to corneal, kidney, bone marrow, pancreas and liver transplants and related services. Procurement of an organ is covered.
5. Surgical assistant services are noncovered when surgery is determined not to require an assistant.
6. See Attachment 3.1-A, #4.b. for physician surgery service limitations for children under 21 years of age.

Concurrent Care

1. Concurrent care services are covered if the consumer has two or more diagnoses involving two or more systems, and if rendering quality care required the special skills of two or more physicians.

KANSAS MEDICAID STATE PLAN

Replacement Page
Attachment 3.1-A
#5.a., page 2

Physicians' Services Limitations

Psychiatric Services

1. Psychotherapy is limited to a total of 32 hours per calendar year. Psychotherapy is noncovered when provided concurrently by the same provider with both targeted case management services and partial hospitalization activity, and brief therapy for crisis or continuing evaluation purposes.
2. Psychotherapy is noncovered on days that a hospital visit is claimed or on days that electroshock treatment is given.
3. Electroshock is limited to twelve inpatient treatments per month and six outpatient treatments per month.
4. Evaluation is limited to two six hours per two calendar years per consumer.
5. See Attachment 3.1-A, #4.b. for physician psychiatric service limitations for children under 21 years of age.

Other Services

1. Eye exams are limited to once every four years excepting:
 - Post cataract surgery consumers within one year of surgery
 - Eye exams required for the treatment of medical conditions (two exams a month are covered)
2. Physician assistant services are limited to those allowed by State law.
3. Inpatient services provided on medically unnecessary days as determined by utilization review are noncovered.
4. See Attachment 3.1-A, #4.b. for other physician service limitations for children under 21 years of age.

substitute per letter dated 6/28/93

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#5.b.

Limitations of Medical and Surgical Services
Furnished by a Dentist (in accordance
with Section 1905(a)(5)(B) of the Act)

Medical and surgical services furnished by a dentist to non-Kan Be Healthy (EPSDT) program participants shall be limited to:

- a) Orocantal fistula closure;
- b) unilateral radical antrotomy;
- c) biopsy of oral tissue;
- d) radical excision of lesion;
- e) excision of tumors;
- f) removal of cysts and neoplasms;
- g) partial ostectomy, guttering or saucerization;
- h) surgical incision for drainage of abscess, removal of foreign bodies, skin, subcutaneous areolar tissue, metal plates, screws or wires, sequestrectomy for osteomyelitis, and maxillary sinusotomy for removal of tooth fragment or foreign body;
- i) treatment of fractures;
- j) closed reduction of dislocation, limitation of motion and related injections;
- k) sutures;
- l) oral skin grafts;
- m) frenulectomy;
- n) excision of pericoronary gingiva;
- o) sialolithotomy;
- p) excision of salivary gland;
- q) sialodochoplasty;
- r) closure of salivary fistula;
- s) emergency tracheotomy;
- t) first 30 minutes of general anesthesia, including materials and apparatus;
- u) professional visits of consultation and hospital call; and
- v) limited prior authorized medical procedures.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#6.a.

(Reserved for future use).

Substitute per email dated 06/26/03.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#6.b.

Optometric Services Limitations

1. Optometric examinations are limited to one complete exam every four years.
2. Two partial exams per month are covered for the treatment of medical conditions.
3. Post-cataract surgery exams are covered, as needed, up to one year following the surgery.
4. Vision therapy is noncovered.
5. Medical care by optometrists is covered according to Kansas licensure limits.
6. Includes one pair of eyeglasses every four years.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#6.c.

(Reserved for future use)

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#6.d.
Page 1

Other Practitioners' Service Limitations

1. Licensed Mental Health Practitioner:

A licensed mental health practitioner (LMHP) is an individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently:

- licensed psychologists,
- licensed clinical marriage and family therapist,
- licensed clinical professional counselor,
- licensed specialist clinical social worker, or
- licensed clinical psychotherapist.

A LMHP also includes individuals licensed to practice under supervision or direction:

- licensed masters marriage and family therapist,
- licensed masters professional counselor,
- licensed masters social worker, or
- licensed masters level psychologist.

Supervision or direction must be provided by a person who is eligible to provide Medicaid services and who is licensed at the clinical level or is a physician.

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. Anyone providing substance abuse treatment services must be licensed under K.S.A. 65-4012, in addition to their scope of practice license.

Inpatient hospital visits are limited to those ordered by the consumer's physician. Visits to nursing facilities are noncovered. Visits to ICFs/MR are limited to testing and evaluation. All services provided while a person is a resident of an IMD are content of the institutional service and not otherwise reimbursable by Medicaid.

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

2. Advanced Registered Nurse Practitioner:

- Anesthesia services are limited to those provided by certified registered nurse anesthetists.
- Obstetrical services are limited to those provided by nurse midwives.
- An ARNP may be an eligible LMHP and can provide all services available to an LMHP that are within the ARNP's scope of practice according to the limitations specified above.
- Other services are limited to those in Attachment 3.1-A #5, Physician's Services Limitations

TN # 06-07 Approval Date OCT 18 2006 Effective Date 07/01/07 Supersedes TN 96-08

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#7.a.

Home Health Nursing Limitations

1. Medically necessary skilled nursing services provided in the home, or via interactive audio and video telecommunication systems by the registered nurse or licensed practical nurse are included. Skilled nursing services are those services requiring substantial and specialized nursing skills. Home telehealth services are delivered as a supplement to enhance home health services, and not as a substitute for face to face visits. Home telehealth services must be ordered by a physician as indicated in the plan of care and the patients must agree to participate in the program.
2. DME services provided for parenteral administration of total nutritional replacements and intravenous medications in the recipient's home require the participation of nursing services from a local home health agency. In areas not served by a home health agency, the services of a local health department or advanced registered nurse practitioner are required.

TN # MS 06-19 Approval Date FEB 07 2007 Effective Date 10/01/06 Supersedes TN# 02-12

Substitute per letter dated 09/20/02

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#7.b.

Home Health Aide Services
Provided by a Home Health Agency - Limitations

Home health aide services are limited to one visit per day per recipient.

Home health aide services are noncovered on the same date of service as restorative aide services for the same recipient.

TN # MS 02-12 Approval Date OCT 09 2002 Effective Date 07/01/02 Supersedes MS 88-20

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Replacement Page
Attachment 3.1-A
#7.c., Page 1

Home Health Services Durable Medical Equipment,
Oxygen, Medical Supplies and Nutritional Replacements
and Intravenous Medications - Limitations

Durable Medical Equipment (DME)

The equipment must be reasonable, necessary and the most economical for the treatment of the patient's illness or injury and be appropriately prescribed by a qualified physician. The equipment must be appropriate for use in the patient's residence. Medical necessity or prior authorization documentation is required for the majority of covered DME items. Provision of DME shall be limited to:

1. Consumers requiring DME for life support;
2. Consumers requiring DME for employment;
3. Consumers who would require higher cost care if the DME were not provided;
4. Consumers residing in nursing facilities who require prior authorized special use equipment.

See Attachment 3.1-A, #4.b., page 8, for DME service limitations for Kan Be Healthy program participants.

Certain DME specified by Health Care Policy/Medical Policy shall be the property of SRS. Used equipment with a warranty specified by Health Care Policy/Medical Policy is used when available. Repair of purchased DME items shall be limited to 75% of the actual purchase price and shall be paid to a supplier.

The least expensive and most appropriate method shall be used for delivery of the equipment. Delivery in excess of 100 miles roundtrip must be prior authorized.

Educational, environmental control and convenience items are noncovered services.

TN # MS 02-12 Approval Date OCT 09 2002 Effective Date 07/01/02 Supersedes MS 96-08

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Attachment 3.1-A
#7.c., Page 2

Home Health Services Durable Medical Equipment, Oxygen Medical Supplies and Nutritional Replacements And Intravenous Medications – Limitations

Oxygen

Oxygen and oxygen delivery equipment are limited and some require medical necessity documentation.

Medical Supplies

1. Medical necessity or prior authorization documentation is required for provision of certain medical supplies.
2. Medical supplies must be necessary and reasonable for treatment of the patient's illness or injury.
3. Medical supplies are to be used in the patient's residence.
4. Medical supplies provided as a home health service must be necessary for providing the home health service.

Nutritional Replacements and Intravenous Medications

DME services provided for parenteral administration of total nutritional replacements and intravenous medications in the recipient's home require the participation of services from a local home health agency, physician, advanced registered nurse practitioner or pharmacist.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#7.d.

Limitations of Physical Therapy, Occupational Therapy, Speech Language Pathology and Restorative Aide Services Provided by a Home Health Agency

Physical, occupational and speech therapy services must be rehabilitative and restorative in nature, provided following physical debilitation due to acute physical trauma or physical illness and must be prescribed by the attending physician. Therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for participants from birth through age 20.

Restorative aide services are limited to those provided under the direction of a registered physical therapist. Restorative aide services must be rehabilitative and restorative in nature, and provided following physical debilitation due to acute physical trauma or physical illness. Restorative aide services are limited to six months' duration. Restorative aide services are non-covered on the same date of service as home health aide services for the same recipient.

The above limitations do not apply to Kan Be Healthy Program Participants. Limitations of physical therapy, occupational therapy, speech language pathology and restorative aide services for Kan Be Healthy program recipients are located in the Kan Be Healthy portion of the State Plan.

KANSAS MEDICAID STATE PLANReplacement Page
Attachment 3.1-A
#9., Page 1**Clinic Services Limitations**Ambulatory Surgical Centers

1. Ambulatory surgical center services are limited to procedures approved by the Division of Medical Programs. Only medically necessary surgical procedures are covered with the exception that elective sterilization procedures are covered.
2. Refer to limitations described in Attachment 3.1-A, #5 (Physician Services) and #10 (Dental Services).

Local Health Departments

1. Home health skilled nursing services.
 - a. Home health skilled nursing services are covered only if located in a county not served by a home health agency meeting Medicare requirements. With the following exception:
 - i. Home visit to the newborn. This home visit is limited to one per consumer within 28 days after the birth date of the infant and must be performed by a registered nurse.
 - b. Home health skilled nursing services require a plan of treatment developed by a physician, and certification by a physician that home health services are needed.
 - c. Home health skilled nursing services must be provided by a registered nurse.
 - d. Medical supplies include but are not limited to dressing materials, disposable syringes, colostomy supplies and catheter supplies.
2. Family planning services.
 - a. Initial family planning visits are limited to one per recipient.
 - b. Annual family planning visits are limited to one per 12 months.
 - c. Interim family planning visits are limited to three per 12 months.
3. The medical components of prenatal care are covered by designated local health departments.
4. Health promotion and risk reduction for pregnant recipients are limited to the following components:
 - a. Risk assessment by a nurse.
 - b. Confirmation of participation in or referral to prenatal care.
 - c. Report to medical provider of recipient's participation in the program.
 - d. Report to recipient on identified risks and suggested remedial measures.
 - e. Referral to appropriate support services.

OCT 18 2002

TN #MS #02-11 Approval Date _____ Effective Date 1/1/03 Supersedes MS #89-11

KANSAS MEDICAID STATE PLANReplacement Page
Attachment 3.1-A
#9., Page 2**Clinic Services Limitations**

- f. Follow-up contact each trimester following initial contact.
 - g. Counseling and teaching in at least three face-to-face contacts.
 - h. Nutrition visits for pregnant women who meet nutrition risk criteria.
5. Laboratory services and immunizations are limited to a state agency-approved listing.
 6. Screening, diagnosis and treatment of sexually-transmitted diseases are covered, with the exception of testing for Acquired Immune Deficiency Syndrome which is free of charge.
 7. Nursing assessments must be performed by registered nurses.
 8. Dental services as described in 3.1-A, #10 - #11 and 3.1-A, #4.b., pages 4 & 5.
 9. See Attachment 3.1-A, #4.b., for Clinic services limitations for children under 21 years of age.

Maternity Centers

1. Maternity center services are limited to those provided by state-licensed centers.
2. Services are limited to normal labor and delivery.

OCT 18 2002

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KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#10

Dental Services Limitations

Services for non-EPSDT participants are limited to:

Medical/dental procedures as follows:

- a) Oronasal fistula closure;
- b) unilateral radical antrotomy;
- c) biopsy of oral tissue;
- d) radical excision of lesion;
- e) excision of tumors;
- f) removal of cysts and neoplasms;
- g) partial osteotomy, guttering or saucerization;
- h) surgical incision for drainage of abscess, removal of foreign bodies, skin, subcutaneous areolar tissue, metal plates, screws or wires, sequestrectomy for osteomyelitis, and maxillary sinusotomy for removal of tooth fragment or foreign body;
- i) treatment of fractures;
- j) closed reduction of dislocation, limitation of motion and related injections;
- k) sutures;
- l) oral skin grafts;
- m) frenulectomy;
- n) excision of pericoronal gingiva;
- o) sialolithotomy;
- p) excision of salivary gland;
- q) sialodochoplasty;
- r) closure of salivary fistula;
- s) emergency tracheotomy;
- t) first 30 minutes of general anesthesia, including materials and apparatus;
- u) each additional 15 minutes of general anesthesia, including materials and apparatus;
- v) consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment);
- w) house/extended care facility call includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed;

JUN 13 2001

TN # MS 01-02 Approval Date _____ Effective Date 4-01-01 Supersedes TN # MS 93-20

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Attachment 3.1-A
#11

Dental Services Limitations (continued)

- x) hospital call may be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed;
- y) limited prior authorized medical procedures; and
- z) limited prior authorized dental procedures associated with medically necessary extractions.

TN # MS 01-02 Approval Date JUN 13 2001 Effective Date 4-01-01 Supersedes TN # MS 93-20

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#11.a.

Physical Therapy Services

Physical therapy services must be rehabilitative and restorative in nature and provided following physical debilitation due to acute physical trauma or illness and must be prescribed by the attending physician. Physical therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for participants from birth through age 20.

Physical therapy services are limited to services provided by inpatient hospital, rehabilitative hospital, Local Education Agencies (early childhood intervention providers, head start and school districts), outpatient, home health and free standing clinics.

Refer also to General Limitations page.

TN # 07-05 Approval Date **JUN 22 2007** Effective Date 04/01/07 Supersedes #01-10

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Attachment 3.1-A
#11.b.

Occupational Therapy Services

Occupational therapy services must be rehabilitation and restorative in nature and provided following physical debilitation due to acute physical trauma or illness and must be prescribed by the attending physician. Occupational therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for participants from birth through age 20.

Occupational therapy services are limited to services provided by inpatient hospital, rehabilitative hospital, Local Education Agencies (early childhood intervention providers, head start and school districts), outpatient, home health and free standing clinics.

Occupational therapy must be provided by an occupational therapist with initial registration from the American Occupational Therapy Association (AOTA) and licensed by the Kansas Board of Healing Arts.

Refer also to General Limitations page.

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Attachment 3.1-A
#11.c., Page 1

Speech, Hearing and Language Services Limitations

Speech and Language Services

1. Speech and language therapy services must be rehabilitation and restorative in nature, and provided following physical debilitation due to acute physical trauma or illness. They must be prescribed by the attending physician.
2. Speech and language therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. There are no time limits for participants from birth through age 20.
3. Speech and language therapy services are limited to services provided by inpatient hospital, rehabilitative hospital, Local Education Agencies (early childhood intervention providers, head start and school districts), outpatient, home health and free standing clinics.
4. Speech therapy must be provided by a speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association.

Hearing Services

1. Services for the hard of hearing are limited to ear examinations by a physician, audiological testing and evaluation by an audiologist, dispensing and fitting of hearing aids, hearing aid repair, trial rental of a hearing aid and hearing aid supplies provided by a certified hearing aid dealer.
2. Provision of a binaural hearing aid requires specific documentation of medical necessity supporting significant bilateral loss of hearing.
3. Hearing aid repairs costing less than \$15.00 are non-covered services. Repairs costing between \$15.00 and \$75.00 are covered. Repairs exceeding \$75.00 are covered only with prior authorization.
4. Trial rental of a hearing aid is limited to one month's duration.
5. Provision of hearing aid batteries is limited to six per month for monaural aids and twelve per month for binaural aids.
6. Hearing aids may be replaced every four years if a medical examination documents the necessity of replacement. 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.

TN # 07-05 Approval Date **JUN 22 2007** Effective Date 04/01/07 Supersedes #03-18

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#12.a.
Page 1

Prescribed Drugs Limitations

Effective January 1, 1991, the Kansas Medicaid Program covers outpatient drugs, in accordance with Sections 1902(a)(54) and 1927 of the Social Security Act, which are covered by a national or State agreement, with the following restrictions or exceptions:

- X A. Prior authorization program which complies with Section 1927(d)(5) of the Social Security Act.

- X B. The following drugs are covered, or restricted, as indicated:
 - X 1. Certain drugs are not covered if the prescribed use is not for a medically accepted indication, as defined by Section 1927(k)(6).

 - X 2. Drugs subject to restrictions pursuant to an agreement between a manufacturer and this State authorized by the Secretary under 1927(a)(1) or 1927(a)(4).

Effective January 1, 2006 the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

- C. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

 The following excluded drugs are covered:

- (a) select anorexiant

- (b) agents when used to promote fertility
(see specific drug categories below)

- (c) agents when used for cosmetic purposes or hair
growth (see specific drug categories below)

TN No. #05-07 Supersedes TN# 91-10 Approval Date JAN 01 2006 Effective Date
January 1, 2006

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Attachment 3.1-A
#12.a.
Page 2

Prescribed Drugs Limitations (continued)

- (d) select agents when used for the symptomatic relief cough and colds
- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
- (f) select nonprescription drugs: Antiarthritics; Antibacterials and Antiseptics; Analgesics; Antipyretics; Antihistamines; Antiemetic/Vertigo Agents; Antimalarial; Gastrointestinal Agents; General Inhalation Agents; Hematinics; Ophthalmic Agents; Respiratory Aids; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasitics; Vaginal Antifungals
- (g) covered outpatient drugs which the manufacture seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- (h) select barbiturates
- (i) select benzodiazepines
- (j) smoking cessation for non-dual eligibles as Part D will cover: select nicotine replacements

No excluded drugs are covered.

These drugs and drug categories are covered for dual eligible individuals to the same extent and with the same restrictions and limitations as they are covered for Medicaid-only individuals.

TN No.#05-07 Supersedes TN# 91-10 Approval Date JAN 01 2006 Effective Date January 1, 2006

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Attachment 3.1-A
#12.a., Page 3

Prescribed Drugs Limitations

Prescribed medications are limited to those prescription-only and over-the-counter drugs, supplies and devices selected for inclusion on the preferred drug list.

Selected specific drug entities or products within specific therapeutic categories shall be covered services only with prior authorization. These are detailed in the provider manual.

The maximum quantity of medication that will be reimbursed for any prescription is a 31 day supply.

Pharmacy services for parenteral administration of total nutritional replacements and intravenous medications in the consumer's home are not covered through the pharmacy program and must be billed through the Home Health Services/Durable Medical Equipment program.

Pharmacy services related solely to non-covered transplant procedures are non-covered.

There will be a limit of five (5) brand name prescription claims allowed per beneficiary per month. The following will be excluded from the limit edit: KBH beneficiaries, antiretroviral drugs, anti-rejection drugs used by transplant patients, chemotherapy drugs, antiemetics, interferon, immune globulins, atypical antipsychotics, antihemophilic drugs and all contraceptives. Pharmacists may utilize an override code to exceed the monthly prescription limit for adult Medicaid recipients if the physician requests additional brand name drugs due to a medical necessity. Children from birth to age 21 will continue to receive an unlimited number of Medicaid-covered prescriptions per month.

TN # MS-02-29 Approval Date FEB 24 2003 Effective Date 01-01-03 Supersedes MS-00-15

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Attachment 3.1-A
#12.a., Page 4

Prescribed Drugs

Kansas shall provide reimbursement for covered outpatient drugs when prescribed by a licensed provider within the scope of their license and practice as allowed by State law within the meaning of Section 1927(k) of Title XIX of the Social Security Act. This will apply to drugs of any manufacturer that has entered into and complies with a rebate agreement with the federal Centers for Medicare and Medicaid Services. The Department may require prior authorization for the reimbursement of any covered outpatient drugs as allowed under the provisions of Section 1927(d)(5) of the Social Security Act. Pursuant to 42 U.S.C. Sec. 1396r-8 and 2002 Session Laws of Kansas, Chapter 180, the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72 hour supply of drugs in emergency circumstances.

For certain classes of drugs, the process for deciding which drugs will be included on the preferred drug list (of those determined to be of similar safety, effectiveness and clinical outcomes) will include a comparison of net drug cost. Net drug cost is determined considering published drug wholesale prices and rebates to the states.

The Director or Division of Health Policy and Finance will appoint a Preferred Drug List Committee to utilize the Drug Utilization Review Board in accordance with federal law. The committee consists of five (5) physicians and four (4) pharmacists who active practice.

JAN 01 2006
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Attachment 3.1-A
#12.a., Page 5

Supplemental Medicaid Rebate Agreement

Based on the requirements of Section 1927 of the Act, the state has the following policies for the supplemental rebate program for Medicaid:

- a) A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid population, submitted to CMS on November 26, 2002 and entitled KSSUP2002 has been approved by CMS.
- b) Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.
- c) The supplemental rebate agreement is applicable only to Medicaid recipients.

Kansas Medicaid recognizes and assures that it will comply with the confidentiality mandate of Section 1927(b)(3)(D) of the Social Security Act.

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Attachment 3.1-A
#12.b.

Dentures Limitations

This page deleted in entirety. Dentures are not provided to non-EPSDT participants.

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Attachment 3.1A
#12c

3.1-A Limitation

#12c Prosthetic Devices

Mileage for fitting prosthetic or orthotic devices requires prior authorization for over 100 miles round trip.

Prosthetic devices are limited to those which replace all or part of an external body member or an internal body organ. They must be prescribed by a physician.

Refer also to General Limitations page.

State Plan

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KANSAS MEDICAID STATE PLAN

Attachment 3.1-a
#12.d.

Eyeglasses Limitations

1. Glasses are limited to one pair every four years excepting post-cataract surgery recipients are covered for up to one year after surgery.
2. Rose tints are noncovered.
3. Other tints are covered when prescribed for medical reasons.
4. Contact lenses require prior authorization.
5. Prior authorization is required for Replacement Procedure Code V2199 - Not otherwise Classified Single Vision Lens - CPF 527; and, Replacement Procedure Code V2299 - Specialty Bifocal Lens (By Report) - CPF 527
6. Plastic lens coating is noncovered.

TN # 99-09 Approval Date AUG 16 1999 Effective Date April 1, 1999 Supersedes TN # 90-11

REHABILITATION SERVICES LIMITATIONS

The following explanation and limitations apply to all rehabilitation services, which are the following:

- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Peer Support
- Crisis Intervention
- Outpatient Substance Abuse Services

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligibles with significant functional impairments resulting from an identified mental health diagnosis or substance abuse diagnosis. The medical necessity for these rehabilitative service must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law, and furnished by or under the direction of a physician, to promote the maximum reduction of symptoms and/or restoration of a recipient to his/her best possible functional level.

Limitations:

Services are subject to prior approval, must be medically necessary, must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan, and must be furnished under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. Anyone providing substance abuse treatment services must be licensed under K.S.A. 65-4601, in addition to their scope of practice license.

Medical necessity of the services is determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy.

Services provided at a work site must not be job tasks oriented. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institute for mental disease (IMD).

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Definitions:

The services are defined as follows:

1. **Community Psychiatric Support and Treatment (CPST)** are goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth

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Attachment 3.1 - A
#13.d
Page 2

in the consumer's individualized treatment plan. CPST is a face-to-face intervention with the consumer 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.

This service may include the following components:

- A. Assist the consumer and family members or other collaterals to identify strategies or treatment options associated with the consumer'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 consumer's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the consumer, with the goal of assisting the consumer 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.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the consumer 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.
- D. Assist the consumer with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the consumer 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.

Provider qualifications: 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 standardized basic training program.

2. Psychosocial Rehabilitation (PSR) services are designed to assist the consumer 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

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#13.d
Page 3

identified goals or objectives as set forth in the consumer's individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the consumer as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the consumer present. Services may be provided individually or in a group setting. The majority of PSR contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

This service may include the following components:

- A. Restoration 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 consumer's social environment including home, work and school.
- B. Restoration 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 consumer with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
- C. Implementing learned skills so the person can remain in a natural community location.
- D. Assisting the consumer with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider qualifications: Must be at least 18 years old, and have an high school diploma or equivalent. Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program.

3. Peer Support (PS) services are consumer 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 consumer's individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for consumers 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 consumer 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. This service may include the following components:

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- A. Helping the consumer to develop a network for information and support from others who have been through similar experiences.
- B. Assisting the consumers 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 treating with their treating clinician.
- C. Assisting the consumer with the identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider qualifications: Must be at least 18 years old, and have a high school diploma or equivalent. Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program. Self identify as a present or former consumer of mental health services.

4. Crisis Intervention (CI) services are provided to a person who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including an preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Interventions are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. 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 person lives, works, attends school, and/or socializes. This service may include the following components:

- A. 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.
- B. Short-term crisis interventions including crisis resolution and de-briefing and follow-up with the individual, and as necessary, with the individuals's caretaker and/or family members.
- C. Consultation with a physician or with other providers to assist with the individuals's specific crisis.

Provider qualifications: Must be at least 18 years old, and 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 standardized basic training program.

5. Outpatient substance abuse services include an array of consumer centered outpatient and intensive outpatient services consistent with the individual's assessed treatment needs, with a

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rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. These services are delivered in a wide variety of settings and are nonresidential services designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment, or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services.

Provider qualifications: Must be licensed under K.S.A. 65-4601.

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Attachment 3.1-A
#14.a.

Services for Individuals Age 65 or
Older in Institutions for Mental Diseases
Inpatient Hospital Services Limitations

Inpatient hospital services for individuals age 65 or older in institutions for mental diseases are covered and subject to the same limitations as detailed previously in Attachment 3.1-A, #1, Inpatient Hospital Services Limitations, with the exception of reserve days.

"Reserve day" means the day that the recipient leaves the institution for mental diseases (IMD) without being discharged, and all of the subsequent days the recipient is not staying at the institution for mental diseases until the day of return. The day of return is not considered or counted as a reserve day.

Reserve days may be for the purposes of acute inpatient medical care in a general hospital, or for therapeutic home visits.

Reserve days are limited to 10 consecutive days for any single episode of acute inpatient medical care in a general hospital per recipient per IMD.

Reserve days are limited to 21 per calendar year for therapeutic home visits. Additional days for therapeutic home visits may be prior authorized.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#14.b.

Limitations of Services for Individuals Age 65 or
Older in Institutions for Mental Diseases,
Skilled Nursing Facility Services

Refer to Attachment 3.1-A, #14.c., for the limitations.

TN/MS-90-47 Approval Date 1/9/91 Effective Date 10/1/90 Supersedes Nothing

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Attachment 3.1-A
#14.c.

Limitations of Services for Individuals
Age 65 or Older in Institutions for
Mental Diseases, Intermediate Care Facilities

1. Each recipient aged 65 or older in an IMD must have a primary diagnosis of a chronic mental condition or a behavior problem which requires 24 hour a day support or assistance in management.
2. Services provided by the IMD shall assist recipients in maximizing their skills for independent living outside of the IMD. The IMD shall provide assistance in securing community resources for the recipient, such as but not limited to community mental health centers, and additional assistance to the recipient in moving to a less restrictive environment than the IMD.
3. Facilities approved for enrollment shall provide services solely to mentally ill recipients, or shall provide services to both mentally ill recipients and geriatric recipients ("dual facilities") if:
 - a. the facility has special approval from SRS,
 - b. the facility houses the mentally ill recipients separately from the geriatric recipients, and
 - c. the facility provides separate and distinct programs to the mentally ill recipients.

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Attachment 3.1-A

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Private Psychiatric Residential Treatment Facility (PRTF)

These programs are intended to provide active treatment in a structured therapeutic environment for children and youth with significant functional impairments resulting from an identified mental health diagnosis, substance abuse diagnosis, and/or a mental health diagnosis with a co-occurring disorder (i.e. substance related disorders, mental retardation/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues). Such services are provided in consideration of a child's developmental stage.

Services must be provided in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals or objectives and be designed to achieve the recipient's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 CFR 441.154 - 441.156.

Recipients of these services must be assessed by a Licensed Mental Health Practitioner (LMHP) or physician who is independent of the treating facility, utilizing an assessment consistent with state law, regulation and policy. Utilizing this assessment a Community Based Services Team (CBST) which complies with the requirement of 42 CFR 441.153 must certify in writing the medical necessity of this level of care in accordance with the criteria and requirements outlined in 42 CFR 441.152. In addition, the need for this level of care will be evidenced by:

- a substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life; and
- the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- all other ambulatory care resources available in the community have been identified and if not accessed determined to not meet the immediate treatment needs of the youth.

After admission, a Licensed Mental Health Practitioner (LMHP) or physician who is independent of the treating facility must re-certify in writing the need for this continued level of care on a regularly scheduled basis as defined by state law, regulation, and/or policy.

Services furnished in a psychiatric residential treatment facility must satisfy all requirements in subpart G of 42 CFR 483 governing the use of restraint and seclusion.

Provider Qualifications:

Providers of Inpatient Psychiatric Services for Individuals under the age of 21 must meet all general requirements for participation as specified in 42 CFR 441.151.

TN # 06-09 Approval Date MAR - 7 2007 Effective Date JUL - 1 2007 ~~01/01/07~~ Supersedes TN 88-08

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Additionally, a psychiatric residential treatment facility must meet the requirements and standards of state certification or licensure, and national accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

Services must be furnished by or under the direction of a physician and all staff must meet applicable licensure and certification requirements and adhere to scope of practice definitions of licensure boards.

Limitations:

An individual under age 22 who has been receiving this service is considered a resident of the PRTF until he is unconditionally released or, if earlier, the date he reaches age 22.

Reserve days, for periods of absence from a PRTF, will be reimbursed to providers with prior approval.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#17

Nurse-Midwife Services Limitations

Nurse-midwife services are limited to those provided by nurse midwives certified as advanced registered nurse practitioners in Kansas, or those with equivalent credentials in their states of practice. Obstetrical services provided by nurse-midwives are subject to the same limitations as those obstetrical services provided by physicians.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#18

Hospice Services Limitations

Hospice services shall be covered for recipients who have been determined to be terminally ill by a physician and who have filed an election statement with a hospice enrolled to participate in the Medicaid Program. Hospice beneficiaries who reside in adult care homes shall have room and board reimbursed.

TN# MS-90-09 Approval Date 4/19/90 Effective Date 4/1/90 Supersedes MS-89-09

#119 Case Management

See Supplement To 3.1A

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#20

Limitations of Extended Services to Pregnant Women

Inpatient General Hospital Services

None except covered services are limited to those determined to be medically necessary by utilization review.

Outpatient General Hospital Services

None.

Physician Services

None.

Prescribed Drugs

Vitamins are limited to prescribed prenatal vitamin supplements.

TN#MS-97-18 Approval Date JAN 07 1998 Effective Date OCT 01 1997 Supersedes TN# MS-89-21

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A

~~#24~~

23

Limitations of Pediatric or Family Nurse Practitioners' Services
Pursuant to OBRA 1989

Pediatric or family nurse practitioners' services shall be limited to the same Physicians' Services Limitations in Attachment 3.1-A, #5, pages 1 and 2 if applicable. Case management services require prior authorization.

TN#MS-90-35 Approval Date 10/4/90 Effective Date 7/1/90 Supersedes Nothing

KANSAS MEDICAID STATE PLAN

Replacement Page
Attachment 3.1-A
#24 a

Transportation Limitations

Ambulance

1. Medical necessity documentation is required for non-emergency ambulance transportation.
2. Non-emergency ambulance transportation is limited to trips to the nearest appropriate facility from the consumer's place of residence and trips from institution to institution.
3. Wheelchair transportation is not covered as ambulance transportation.

Non-emergency Medical Transportation (NEMT)

1. Prior authorization is required for all "non-commercial," non-emergency medical transportation. Prior authorization is required for "commercial," non-emergency medical transportation that is reimbursed at a "level two" rate, for beneficiaries who are non-ambulatory or have specialized medical equipment which cannot be removed during transit, or are receiving specialized medical treatment resulting in a disabling physical condition.
2. Limitations do not apply to emergency transportation (trips for medical services which cannot be delayed for prior authorization).
3. Non-emergency medical transportation is limited to Medicaid beneficiaries, receiving Medicaid covered services, for medical purposes, and when no other less expensive mode of transportation is available.
4. Payment for waiting time is not allowed.
5. Subsistence (food and lodging) is limited to the beneficiary.
6. See Attachment 3.1-A, #4.b. for transportation service limitations for children under 21 years of age.

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KANSAS MEDICAID STATE PLAN

Attachment 3.1-A

#18.d.

23d 24d

3.1-A Limitation
#18.d. Skilled Nursing Facility Services
for Patients Under 21 Years

Services rendered to recipients under the age of sixteen require prior authorization.

TN/MS-85-18 Approval Date 7/18/85 Effective Date 4/1/85 Supersedes TN# _____

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#24.e

Medical Services Limitations for Certain Alien Individuals

Non-qualified aliens, ineligible aliens meeting state residency requirements and qualified aliens subject to the five year bar until the bar has expired in accordance with P.L. 104-193 who meet other requirements for Medicaid are eligible for the following services:

- (1) Emergency services required after the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - (i) Placing the patient's health in serious jeopardy;
 - (ii) Serious impairment to bodily functions; or
 - (iii) Serious dysfunction of any bodily organ or part.

KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#24f

Limitations of personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse

Medical attendant care for independent living is covered with prior authorization and up to a maximum of 24 hours a day. Medical attendant care for independent living is not covered at the same time as HCBS medical attendant during the same period of time.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

CASE MANAGEMENT SERVICES

A. Target Group:

The target group consists of children participating in the Kan Be Healthy Program and who are technology dependent. These individuals are under the age of 22 and require daily ongoing medical care and monitoring by trained medical personnel because of chronic disability. The chronic disability must require the routine use of a medical device to compensate for the loss of respiratory function or require the need for total parenteral nutrition.

B. Areas of State in which services will be provided:

- Entire State.
- Only in the following geographic areas (authority of section 1915(g) (1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services:

- Services are provided in accordance with section 1902(a) (10) (B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902(a) (10) (B) of the Act.

D. Definition of Services:

Case management services for technology dependent children consist of referral for assessment, referral for treatment based upon the assessment, and the locating, coordinating and monitoring of the provision of services.

E. Qualification of Providers:

Providers of case management services for technology dependent children must be advanced registered nurse practitioners.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- H. Within one year from the date CMS approves this state plan amendment, or upon CMS approval of an HCBS waiver, whichever is earlier, the State will eliminate ACIL services from the State Plan and provide these services under HCBS.

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Adults with Severe and Persistent Mental Illness or Children with Serious Emotional Disturbance

Target Group: Medicaid beneficiaries who meet the functional assessment criteria for adults with severe and persistent mental illness or children with serious emotional disturbance.

Areas of state in which services will be provided:

Entire State of Kansas

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

Definition of services: Case management services are defined as those services which will assist the individual in gaining access to medical, social, educational and other needed services. Targeted Case Management includes any or all of the following services:

Assessment of an eligible individual to determine service needs by:

- taking client history,
- identifying the individual's needs and completing the related documentation, and
- gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.

Development of a specific care plan that:

- is based on the information collected through the assessment,
- specifies the goals and actions to address the medical, social, educational, and other service needs of the individual,
- includes activities such 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 such goals, and identify

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State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Adults with Severe and Persistent Mental Illness or Children with Serious Emotional Disturbance (continued)

- a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities, including:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to determine:
 - whether services are being furnished in accordance with the individual's care plan;
 - whether the services in the care plan are adequate; and
 - whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with the providers.

Qualifications of providers:

- 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 experience substituting for one year of education,
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or serious emotional disturbance, and the ability to react effectively in a wide variety of human service situations,
- Meet the specifications outlined in the State of Kansas, Department of Social and Rehabilitation Services licensing standards in regard to any ongoing requirements, including completion of training requirements according to a curriculum approved by the state,

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Adults with Severe and Persistent Mental Illness or Children with Serious Emotional Disturbance (continued)

- Pass Kansas Bureau of Investigation, Department of Social and Rehabilitation Services child abuse check, adult abuse registry and motor vehicle screens,
- The TCM provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional or a Licensed Mental Health Practitioner approved by the state or its designee with experience regarding this specialized mental health service.

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

The State of Kansas has been granted a waiver of section 1902(a)(23)

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations: Caseload size must be based on the needs of the clients/families with an emphasis on successful outcomes and consumer satisfaction and must meet the needs identified in the care plan. The following general ratio (Full time equivalent (FTE) to Medicaid eligibles) should serve as a guide: 1 FTE to 35 eligibles. Individuals who provide Targeted Case Management services to a participant may not provide other direct services to that participant.

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Mental Retardation and Other Developmental Disabilities

Target Group: Persons with mental retardation or other developmental disabilities. Mental retardation means substantial limitations in present functioning that is manifest during the period from birth to 18 years and is characterized by significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable skill areas: communication, self-care, home living, social skills, community use, self direction, health and safety, functional academics, leisure and work.

Developmental disabilities means mental retardation or a severe, chronic disability, which is attributable to a mental or physical impairment, a combination of mental and physical impairments, or a condition which has received a dual diagnosis of mental retardation and mental illness, is manifest before 22 years of age; and is likely to continue indefinitely. In the case of a person five years of age or older, results in substantial limitation in three or more of the following areas of major life functioning: self care, receptive and expressive language development and use, learning and adapting, mobility, self direction, capacity of independent living and economic self-sufficiency; reflects a need for a combination and sequence of special interdisciplinary or generic care, treatment of other services which are life long, or extended in duration, are individually planned or coordinated, and does not include individuals who are solely and severely emotionally disturbed or seriously or persistently mentally ill or have disabilities solely as result of infirmities of aging.

Areas of state in which services will be provided:

Entire State of Kansas

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

Definition of services: Case management services are defined as those services which will assist the individual in gaining access to medical, social, educational and other needed services. Targeted case management includes any or all of the following services:

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State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Mental Retardation and Other Developmental Disabilities (continued)

Assessment of an eligible individual to determine service needs by:

- taking client history,
- identifying the individual's needs and completing the related documentation, and
- gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.

Development of a specific care plan that:

- is based on the information collected through the assessment,
- specifies the goals and actions to address the medical, social, educational, and other service needs of the individual,
- includes activities such 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 such goals, and identify a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an individual obtain needed services including,
- activities that help link the individual with medical, social, educational providers, or
- other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities including:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to determine:
 - whether services are being furnished in accordance with the individual's care plan;
 - whether the services in the care plan are adequate; and
 - whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with the providers.

Qualifications of providers:

Case management services are provided by providers who meet licensing standards of the State of Kansas or its designee, and who are qualified enrolled Medicaid providers; and

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State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Mental Retardation and Other Developmental Disabilities (continued)

- Six months full time experience in a field of human services; and
- A bachelors degree or additional full-time experience in the field of developmental disabilities services, which may be substituted for the degree at the rate of six-months of full-time experience for each missing semester of college; and
- Completion and passing of the Social and Rehabilitation Services Community Supports and Services case management training and assessment

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations:

Targeted Case Management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

'Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition.'

Claims will be made for targeted case management services (TCM) delivered to an eligible person prior to leaving a medical institution only when the person is enrolled in a 1915(c) waiver program.

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM-87-4 (BERC)
March 1987

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OMB No.: 0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

(Reserve for future use)

TN # 07-06 Approval Date DEC - 6 2007 Effective Date 04/01/07 Supersedes TN # 02-01

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Frail Elderly

Target Group: Individuals who are Medicaid eligible, are age 65 or older, meet the Medicaid long-term care threshold as determined by a qualified assessor, and are not being served on the Home and Community Based Services waiver for the Physically Disabled program.

Areas of state in which services will be provided:

Entire State of Kansas

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

Definition of services: Targeted case management services are defined as those services which will assist the individual in gaining access to medical, social, educational and other needed services. Targeted Case Management includes any or all of the following services:

Assessment of an eligible individual to determine service needs by:

- taking client history,
- identifying the individual's needs and completing the related documentation, and
- gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.

Development of a specific care plan that:

- is based on the information collected through the assessment,
- specifies the goals and actions to address the medical, social, education, and other service needs of the individual,
- includes activities such 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 such goals, and identify a course of action to respond to the assessed needs of the eligible individual.

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Frail Elderly

Referral and related activities:

- to help an individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities, including:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to determine:
 - whether services are being furnished in accordance with the individual's care plan;
 - whether the services in the care plan are adequate; and
 - whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with the providers.

Qualifications of providers:

1. Must be a Medicaid enrolled provider of Targeted Case Management.
2. Must participate in all state mandated HCBS/FE or FE Targeted Case Management training to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by the state agency administering the program.
3. Cannot be employed by or have a contract with any entity which creates a conflict of interest by providing Home and Community Based Services/Frail Elderly waiver direct services, including but not limited to, self-direct/payroll agent services.
4. Must meet the following qualifications:
 - a. An individual with a four (4) year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, and, that individual has at least one (1) year experience in the geriatric services field; or
 - b. A Registered Professional Nurse licensed to practice in the State of Kansas with at least one (1) year experience in the geriatric service field; or

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Frail Elderly

- c. An individual with at least one (1) year experience on or before January 1, 1997 as a SRS LTC case manager that is in good standing; or
- d. Individual with a High School or General Education Diploma and four (4) years work experience in the human services field with an emphasis in aging services; or a combination of work experience in the human services field and post-secondary education, with one (1) year of work experience substituting for one (1) year of work education.

Individuals that meet this qualification may only provide specific identified tasks approved by the Kansas Department on Aging and must be supervised by an individual that meets the qualifications in 3a, 3b, or 3c. Supervisory time is not billable.

- e. An individual with a High School or General Education Diploma and one (1) year work experience

Individuals that meet this qualification may only provide specific identified tasks approved by the Kansas Department on Aging and must be supervised by an individual that meets the qualifications in 3a, 3b, or 3c. Supervisory time is not billable.

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- 1. Eligible recipients will have free choice of the providers of case management services.
- 2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations:

The maximum allowable units per customer are 800 units per year. Targeted Case Management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

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State/Territory Kansas

(Reserved for future use)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory Kansas

(Reserved for future use)

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
Traumatic Brain Injury

Target Group: Medicaid eligible individuals with Traumatic Brain Injury (TBI) ages 16 through 64 and consumers over age 64 who are receiving services on the HCBS TBI waiver, who meet the criteria for TBI Rehabilitation Facility placement as determined by a qualified Targeted Case Manager.

Areas of state in which services will be provided:

Entire State of Kansas

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

Definition of services: Case management services are defined as those services which will assist the individual in gaining access to medical, social, educational and other needed services. Targeted Case Management includes any or all of the following services:

Assessment of an eligible individual to determine service needs by:

- taking client history,
- identifying the individual's needs and completing the related documentation, and
- gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.

Development of a specific care plan that:

- is based on the information collected through the assessment,
- specifies the goals and actions to address the medical, social, educational, and other service needs of the individual,
- includes activities such 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 such goals, and identify a course of action to respond to the assessed needs of the eligible individual.

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TARGETED CASE MANAGEMENT SERVICES
Traumatic Brain Injury (continued)

Referral and related activities:

- to help an individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities, including:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to determine:
 - whether services are being furnished in accordance with the individual's care plan;
 - whether the services in the care plan are adequate; and
 - whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with the providers.

Qualifications of providers:

- At least six months personal experience with a disability as recognized by the Rehabilitation Act of 1973; or
- At least one year of professional experience providing services, or case management to a person or persons with a disability; and
- At least 12 hours of standardized training, annually, in the history and philosophy of the National Independent Living Movement.
- Completion of a standard practicum, to include: 1) observation of an assessment or assessments conducted by at least one qualified Targeted Case Manager, and 2) development of at least four assessments by the trainee, with monitoring and feedback provided by at least one qualified Targeted Case Manager; and
- 40 hours of training annually, in topics related to Traumatic Brain Injury; and

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Traumatic Brain Injury (continued)

- An annual demonstration of knowledge and proficient application of the services, rules, policies, and procedures of the HCBS/TBI waiver program. This is an agency responsibility and should be recorded in the TBI-TCM's personnel file.

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations:

The amount of Targeted Case Management provided is limited to 640 units per calendar year, (1 unit=15 minutes). This limitation may be waived through prior approval from SRS.

Targeted Case Management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

'Targeted case management, (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, education and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition.'

Claims will be made for targeted case management services (TCM) delivered to an eligible person prior to leaving a medical institution only when the person is enrolled in a 1915(c) waiver program.

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State/Territory: Kansas

(Reserved for future use)

State Plan under Title XIX of the Social Security Act
State/Territory: Kansas

TARGETED CASE MANAGEMENT SERVICES
PHYSICAL DISABILITY

Target Group: Medicaid eligible individuals, 16-65 years of age, who meet functional criteria for nursing facility placement and disability determination by Social Security standards. Those individuals 65 years of age and older who meet functional criteria for nursing facility placement and disability determination by Social Security standards, and were being served by the Home and Community Based Services Physical Disability waiver prior to age 65.

Areas of state in which services will be provided:

Entire State of Kansas

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope.

Definition of services: Case management services are defined as those services which will assist the individual in gaining access to medical, social, educational and other needed services. Targeted Case Management includes any or all of the following services:

Assessment of an eligible individual to determine service needs by:

- taking client history,
- identifying the individual's needs and completing the related documentation, and
- gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.

Development of a specific care plan that:

- is based on the information collected through the assessment,
- specifies the goals and actions to address the medical, social, educational, and other service needs of the individual,
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized

State Plan under Title XIX of the Social Security Act
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**TARGETED CASE MANAGEMENT SERVICES
PHYSICAL DISABILITY (continued)**

- health care decision maker) and others to develop such goals, and identify a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities, including:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to determine:
 - whether services are being furnished in accordance with the individual's care plan;
 - whether the services in the care plan are adequate; and
 - whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with the providers.

Qualifications of providers:

- Must have successfully completed the Independent Living Counseling examination
- Must have at least six months personal experience with a disability or as recognized by the Rehabilitation Act of 1973 (as amended); or
- Have at least one year professional experience providing direct services to persons with a variety of disabilities
- Must have annual independent Living Philosophy training consisting of 12 hours of standardized training in history and philosophy of the National Independent Living movement; and
- Must participate in all state mandated HCBS/PD or Independent Living Counseling training to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by the state agency administering the program; and
- Must be a Medicaid-enrolled provider of Independent Living Counseling.

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**TARGETED CASE MANAGEMENT SERVICES
PHYSICAL DISABILITY (continued)**

Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations:

The maximum allowable units per customer are 480 units per year. One unit equals 15 minutes. This may be waived with prior authorization by Social and Rehabilitation Services, Health Care Policy.

Targeted Case Management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

'Targeted case management, (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, education and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition.'

Claims will be made for targeted case management services (TCM) delivered to an eligible person prior to leaving a medical institution only when the person is enrolled in a 1915(c) waiver program.

State Agency

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State Agency

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**TARGETED CASE MANAGEMENT SERVICES
Family Services Coordination**

A. Target Group

Medicaid eligible children birth to three years of age that have a developmental delay or a known condition leading to a developmental delay or an established risk for developmental delay.

"Developmental delay" means any of the following conclusions obtained using the appropriate instruments and procedures in one of more areas of development including adaptive, cognitive, physical, communication, and/or social or emotional:

- (1) There is a discrepancy of 25 percent or more between chronological age, after correction for prematurity and developmental age in any one area;
- (2) The child is functioning at 1.5 standard deviations below the mean in any one area;
- (3) There are delays of at least 20 percent or at least one standard deviation below the mean in two or more areas;
- (4) The clinical judgment of the multidisciplinary team concludes that a developmental delay exists when specific tests are not available or when testing does not reflect the child's actual performance. The professional(s) in the area or areas of delay shall be on the multidisciplinary team.

"Established risk for developmental delay" means a diagnosed mental or physical condition that has a high probability of resulting in developmental delay. The delay may or may not be exhibited at the time of diagnosis, but the common history of the disorder indicates the need for early intervention services.

B. Areas of state in which services will be provided:

Entire State of Kansas

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TARGETED CASE MANAGEMENT SERVICES
Family Services Coordination

 Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.)

C. Comparability of services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

 Services are not comparable in amount duration and scope.

D. Definition of services:

Targeted case management services are defined as those services which will assist the individual in gaining access to medical, social, educational and other needed services. Targeted Case Management includes any or all of the following services:

Assessment of an eligible individual to determine service needs by:

- taking client history,
- identifying the individual's needs and completing the related documentation, and
- gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.

Development of a specific care plan that:

- is based on the information collected through the assessment,
- specifies the goals and actions to address the medical, social, educational, and other service needs of the individual,
- includes activities such 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

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TARGETED CASE MANAGEMENT SERVICES Family Services Coordination

develop such goals, and identify a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or
 - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities, including:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to determine:
 - whether services are being furnished in accordance with the individual's care plan;
 - whether the services in the care plan are adequate; and
 - whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with the providers.

E. Qualifications of providers:

- Professionals providing TCM Family Services Coordination must meet State approved or recognized certification, licensing, registration or other comparable requirements that apply to the area in which the individuals are providing early intervention services.
- Must have successfully completed the Introduction to TCM Family Services Coordination training.

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**TARGETED CASE MANAGEMENT SERVICES
Family Services Coordination**

- Must participate annually in 8 hours of state or local sponsored Part C Infant-Toddler training to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by the state agency.
- Must have demonstrated knowledge and understanding about the nature and scope of medical, social, educational and other services which are accessed by eligible infants and toddlers and their families.

F. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Payment

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Limitations

Targeted Case Management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

KANSAS MEDICAID STATE PLAN

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Page 1

State of Kansas PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency:

The State Medicaid Agency, Kansas Division of Health Policy and Finance (DHPF), is the Administering Agency, and under the authority of state statute and an interagency cooperative agreement, DHPF delegates the administration of the PACE program to the Kansas Department on Aging, 503 S. Kansas Avenue, Topeka, Kansas 66603.

The state limit of PACE enrollees to be funded is 350.

I. Eligibility

A. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

KANSAS MEDICAID STATE PLAN

Supplement 3 to Attachment 3.1-A
Page 2

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. N/A The following standard included under the State plan (check one):

- (a) SSI
- (b) Medically Needy
- (c) The special income level for the institutionalized
- (d) Percent of the Federal Poverty Level: %
- (e) Other (specify):

2. X The following dollar amount: \$ 716

Note: If this amount changes, this item will be revised.

3. N/A The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

- 1. SSI Standard
- 2. Optional State Supplement Standard
- 3. Medically Needy Income Standard
- 4. The following dollar amount: \$
Note: If this amount changes, this item will be revised.
- 5. The following percentage of the following standard that is not greater than the standards above: % of standard.
- 6. The amount is determined using the following formula:

Note: If this amount changes, this item will be revised.

3. The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1. The following standard under 42 CFR 435.121:

2. The Medically needy income standard

3. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

5. The amount is determined using the following formula:

6. Not applicable (N/A)

(C.) Family (check one):

1. AFDC need standard

2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

5. The amount is determined using the following formula:

6. Other

7. Not applicable (N/A)

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. X Rates are set at a percent of fee-for-service costs
2. Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. Adjusted Community Rate (please describe)
4. Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mercer, Marsh & McLennan Companies

The PACE rate for Medicaid is established based upon services rendered to the SSI and Medically Needy populations residing in the service area. The upper payment limits (UPLs) include the aged, blind, and disabled populations that are age 55 and older. The most recent claims data is used for all services including targeted case management, with the exception of Medicare Part A and Part B premiums (Medicare buy-in). No data is used for individuals that are eligible for any current capitated managed care program. Data for persons with a living arrangement of ICF/MR, HCBS/MR, NF-MH, or state hospital are excluded. Data for persons without any identified living arrangement are also excluded. Only data for persons with a living arrangement in a NF or the PD or FE waivers are included. The costs in the base period are inflated to the present for rate setting purposes. Inflation is based on state historical costs.

Beneficiary eligibility data for the same time period as the claims data and with the same exclusions as above is used. This data was analyzed in a manner similar to that used for capitated managed care rate setting. Potential UPLs on a per member per month basis are computed by population, living arrangement, age groups, gender, and service areas. The break out of the UPL is reviewed for the possibility of unusual data, more commonly referred to as outliers, and for differences in average distributions. If no difference in average distributions is determined, a single UPL will be proposed for each eligibility category, otherwise a breakout in average distributions will be used.

An analysis of claims completion is made to determine whether a factor adjustment is needed. This factor is then negotiated with the provider.

Actual fee for service expenditures by Medicaid are used to calculate the UPL with the exceptions noted below. The PACE provider shall be responsible for collection of and reporting of third party liability. No adjustment is necessary to payments because claims do not reflect any receipts of third party liability by Medicaid. Postpay recoveries for all of Medicaid averaged 0.65% during this time period. As a result a reduction in expenditures of 0.65% was made as this would be the responsibility of the PACE provider. Adjustments to expenditures are made equal to the amount of average Medicaid pharmacy rebates received. The percentage is based upon the aggregate receipt of pharmacy rebates versus aggregate pharmacy payments as rebates cannot readily be identified to a particular population or county of residence. Copayment, which is a reduction in actual payment, is added back into the UPLs as the provider will not be allowed to charge copayment. Certified match expenditures are added to the UPLs. There may be instances when the provider certifies that state funds are available and the State will not pay for these funds. Medicare Part D medication drugs were deducted from the UPL.

Disproportionate share payments are not included in any claims data as they cannot be identified to a particular beneficiary, nor will they be the responsibility of the PACE provider.

For those individuals who have client participation for cost of care requirements, the actual rate paid will be the applicable rate less the client participation for that particular person.

In order to set UPLs for a future time period, trend factors will be completed at least every 5 years. Separate trends for the following are computed using the same methodology that is used for the SRS budget process:

- SSI Aged regular medical expenditures (all expenditures except for long term care and HCBS related),
- SSI Blind and Disabled regular medical expenditures,
- Medically Needy Aged regular medical expenditures,
- Medically Needy Blind and Disabled regular medical expenditures,
- HCBS/FE expenditures,
- HCBS/PD expenditures,
- FE targeted case management expenditures, and
- Nursing facility expenditures.

The UPL will be discounted by a budget savings factor determined by the State to arrive at the final rates paid. The budget savings factor will be based upon: negotiations with the provider, efficient operation of the PACE site, savings to be accrued to the State Agency, and the experience of the PACE site. The State will document its rationale for choosing the specific budget percentage factor in its submittal to the CMS RO with the annual rates.

- C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

ATTACHMENT 3.1-B

**Amount, Duration and Scope of Services
All Medically Needy Groups**

Attachment 3.1-B

In the following pages, the note appearing at the bottom of the page indicates a reference to Attachment 3.1-A--Service Limitations.

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SEPTEMBER 1986

ATTACHMENT 3.1-B
Page 1
OMB No. 0938-0193

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

The following ambulatory services are provided.

Refer to Attachment 3.1-A. The same scope of services is provided to the medically needy as is provided to the categorically needy.

* Description provided on attachment.

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Supersedes
TN No. MS-82-20

Approval Date 01/06/87

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HCFA ID: 0140P/0102A

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: No limitations With limitations*

2. a. Outpatient hospital services.

Provided: No limitations With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan).

Provided: No limitations With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: No limitations With limitations*

3. Other laboratory and x-ray services.

Provided: No limitations With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Provided: No limitations With limitations*

c. Family planning services and supplies for individuals of childbearing age.

Provided: No limitations With limitations*

*Description provided on Attachment 3.1-A.

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May 1993

ATTACHMENT 3.1-B
Page 2a
OMB No.

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

5. a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.
- Provided: No limitations With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
- Provided: No limitations With limitations*
- Not provided

*Description provided on Attachment 3.1-A.

TN No. 05-07 Supersedes MS 93-22 Approval Date JAN 01 2006 Effective Date January 1, 2006

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' Services
 Provided: No limitations With limitations*
 - b. Optometrists' Services
 Provided: No limitations With limitations*
 - c. Chiropractors' Services
 Provided: No limitations With limitations*
 - d. Other Practitioners' Services
 Provided: No limitations With limitations*
7. Home Health Services
- a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
 Provided: No limitations With limitations*
 - b. Home health aide services provided by a home health agency.
 Provided: No limitations With limitations*
 - c. Medical supplies, equipment, and appliance suitable for use in the home.
 Provided: No limitations With limitations*
 - d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
 Provided: No limitations With limitations*

*Description provided on Attachment 3.1-A.

TN No. 06-12 Supersedes MS 05-07 Approval Date SEP 28 2006 Effective Date July 1, 2006

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

- 8 Private duty nursing services
 Provided: No limitations With limitations*
 Not provided.
- 9 Clinic services.
 Provided: No limitations With limitations*
10. Dental services.
 Provided: No limitations With limitations*
11. Physical Therapy and related services.
a. Physical Therapy.
 Provided: No limitations With limitations*
b. Occupational Therapy
 Provided: No limitations With limitations*
c. Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech pathology or audiologist).
 Provided: No limitations With limitations*
12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
a. Prescribed drugs.
 Provided: No limitations With limitations*
b. Dentures.
 Provided: No limitations With limitations*
 Not provided.

*Description provided on Attachment 3.1-A.

TN No. 05-07 Supersedes MS 86-43 Approval Date JAN 01 2006 Effective Date January 1, 2006

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

- c. Prosthetic devices.
 Provided: No limitations With limitations*
- d. Eyeglasses.
 Provided: No limitations With limitations*
13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic services.
 Provided: No limitations With limitations*
 Not provided.
- b. Screening services.
 Provided: No limitations With limitations*
 Not provided.
- c. Preventive services.
 Provided: No limitations With limitations*
 Not provided.
- d. Rehabilitative services
 Provided: No limitations With limitations*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
 Provided: No limitations With limitations*
- b. Skilled nursing facility services.
 Provided: No limitations With limitations*

*Description provided on Attachment 3.1-A.

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

- c. Intermediate care facility services.
 Provided: No limitations With limitations*
15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
 Provided: No limitations With limitations*
- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
 Provided: No limitations With limitations*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
 Provided: No limitations With limitations*
17. Nurse-midwife services.
 Provided: No limitations With limitations*
18. Hospice care (in accordance with section 1905(o) of the Act).
 Provided: No limitations With limitations*
 Not provided.

*Description provided on Attachment 3.1-A.

TN No. 05-07 Supersedes MS 89-28 Approval Date JAN 01 2006 Effective Date January 1, 2006

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

19. Case Management services and Tuberculosis related services.
- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a) (19) or section 1915(g) of the Act).
- Provided: No limitations With limitations*
- Not provided.
- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.
- Provided: No limitations With limitations*
- Not provided.
20. Extended services for pregnant women
- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
- Provided: + Additional coverage ++
- b. Services for any other medical conditions that may complicate pregnancy.
- Provided: Additional coverage Not provided.
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on Attachment 3.1-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

21. Certified pediatric or family nurse practitioners' services.
- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a) (19) or section 1915(g) of the Act).
- Provided: No limitations With limitations*
- Not provided.
- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on Attachment 3.1-A.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

- Provided: No limitations With limitations*
 Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Director

a. Transportation

- Provided: No limitations With limitations*

b. Services of Christian Science nurses.

- Provided: No limitations With limitations*
 Not provided.

c. Care and services provided in Christian Science sanatoria.

- Provided: No limitations With limitations*
 Not provided.

d. Skilled nursing facility services provided for patients under 21 years of age.

- Provided: No limitations With limitations*

e. Emergency hospital services.

- Provided: No limitations With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

- Provided: No limitations With limitations*

Not provided.

*Description provided on Attachment 3.1-A.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

24. Pediatric or family nurse practitioner's services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89):

Provided: No limitations With limitations*

*Description provided on Attachment 3.1-A.

State/Territory: Kansas

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY
NEEDY GROUP(S): _____

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided x not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

___ provided: ___ State Approved (Not Physician) Service Plan Allowed
 ___ Services Outside the Home Also Allowed
 ___ Limitations Described on Attachment

x not provided

KANSAS MEDICAID STATE PLAN

**Attachment 3.1-B
Page 10**

**State of Kansas
PACE State Plan Amendment Pre-Print**

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically
Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in
Supplement 3 to Attachment 3.1-A.

 X Election of PACE: By virtue of this submittal, the State elects PACE as an
optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add
PACE as an optional State Plan service.

ATTACHMENT 3.1-C

Standards and Methods of Assuring High Quality Care

KANSAS MEDICAID STATE PLAN

Standards and Methods of Assuring High Quality Care

The following is a description of the standard established and the methods that are used to assure that the medical and remedial care and services are of high quality.

1. Medical care and services are provided in accordance with the overall objectives of maintaining good health, preventing disease and disability, curing and mitigating disease, and rehabilitating the individual.
2. Plans for medical care are integrated with social planning.
3. Medical care and service shall be provided within the licensure of the provider.
4. In so far as possible, medical care and service shall permit the recipient to exercise free choice in the selection of his or her provider.
5. The amount and kind of medical care and service are determined by the professional opinion of the practitioner.
6. Medical care and services not provided by a licensed professional person must be recommended or prescribed by a licensed professional person.
7. Care in adult care homes or hospitals for the geriatric and debilitated must be provided in a facility licensed to provide the required care.
8. The state agency will establish processes of utilization review for each item of care and service included in the Medicaid/MediKan Program in accordance with the requirements set forth in the Kansas Administrative Regulations. The agency will be responsible for all utilization review plans and activities in the program.

TN No. MS-86-02
Supersedes
TN No. _____

Approval Date 4/7/86

Effective Date 1/1/86

KANSAS MEDICAID STATE PLAN

Standards and Methods of Assuring High Quality Care

9. A regular program of medical review (including medical evaluation of each patient's need for skilled nursing facility care and inspection of care for recipients in intermediate care facilities as to the need for such placement) is provided. In the case of individuals in mental hospitals, review is provided of the need for care in a mental hospital, including, where applicable, evaluation of a written plan of care, and a plan of rehabilitation prior to admissions. Inspections of care will be made in all skilled nursing facilities and mental institutions within the state by one or more medical institutions within the state by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) and in all intermediate care facilities (by review teams composed of R.N.'s and social workers, or other appropriate personnel). The review will determine the adequacy of the services available to meet the current health needs and to promote the maximum physical well-being of patients, the necessity and desirability of the continued placement of these patients, and the feasibility of meeting their health care needs through alternate institutional or non-institutional services. Further, such team or teams will make full and complete reports of the findings resulting from such inspections together with any recommendations the Adult Care Home Program, Adult Services, with reports being available to the agency administering the State Plan.

10. Public or private institutional facilities are licensed by the Kansas Department of Health and Environment. In addition, they have been determined to meet the requirements as specified in the Kansas Administrative Regulations.

TN No. MS-86-02
Supersedes
TN No. _____

Approval Date 4/7/86

Effective Date 1/1/86

ATTACHMENT 3.1-D

Methods to Assure Transportation

KANSAS MEDICAID STATE PLAN

Attachment 3.1-D

Methods to Assure Transportation

Kansas assures that transportation services are available to Medicaid recipients. Non-emergent Medical Transportation (NEMT) services are covered when provided for medical purposes and only when an eligible Medicaid beneficiary is in the vehicle. Transportation must be to covered services provided by Medicaid and contract network providers, as described in the Kansas Medical Assistance Program (KMAP) medical benefits brochure which provides information about available transportation; and the Kansas Medical Assistance Provider Manual which supplies information to providers about covered services.

General Guidelines –

Covered when no other mode of transportation is available.

The least expensive means of transportation (appropriate to the beneficiary's medical need) must be used.

Transportation is available for services received within the State of Kansas or within 50 miles of the Kansas border, provided that the beneficiary is traveling to the closest available provider for his or her medical condition. Reimbursement is not made if the beneficiary chooses to travel to another community for a service that is available in their community.

Transportation must be provided by an enrolled transportation provider .

NEMT is covered for necessary medical visits. Subsistence may be covered for Medicaid recipients.

See Attachment 3.1-A, #4.b. for transportation service limitations for children under 21 years of age.

ATTACHMENT 3.1-E

Standards for the Coverage of Organ Transplant Services

Revision: HCFA-PM-87-4
December, 1998

Attachment 3.1-E
Page 1
OMB No. 0938-0193

State/Territory: Kansas

STANDARDS FOR COVERAGE OF ORGAN TRANSPLANT SERVICES

Kansas assures that similarly situated individuals are treated alike in the coverage of organ transplants. Cornea, kidney, bone marrow, pancreas and liver transplants are covered. There are no restrictions on the facilities or practitioners which provide such procedures which would diminish the accessibility of high quality care to individuals eligible for transplants.

LKK copy

state medicaid manual

Part 4 — Services

cc to [unclear] 9-29
except [unclear]

Department of Health
and Human Services
Health Care Financing
Administration

Transmittal No. 39

Date NOVEMBER 1988

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NEW IMPLEMENTING INSTRUCTIONS—EFFECTIVE DATE: January 1, 1987

Section 4201, Organ Transplants.—This section advises States choosing to cover organ transplants that they must furnish written standards for the coverage of these procedures which contain provisions concerning similarly situated individuals, facility and practitioner restrictions and sufficiency of services.

NOTE: This statutory requirement was enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) in §9507. It was implemented initially through a change in the State Plan Preprint distributed to States via Program Memorandum No. 87-4 in March 1987.

KANSAS SOCIAL AND
REHABILITATION SERVICES

NOV 22 1988

OFFICE OF THE
SECRETARY

PART 4

SERVICES

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4201. ORGAN TRANSPLANTS

A. Background.—Section 1903(i) of the Social Security Act requires the denial of Federal Financial Participation (FFP) for organ transplants unless the State plan provides written standards concerning the coverage of such procedures. The statute does not list the transplant procedures for which standards must be written, but the organs about which questions are most commonly asked are: cornea, kidney, heart, liver, bone marrow, pancreas and combined heart-lung. You can choose to cover no organ transplant procedures, some types of transplants and not others, or all transplants. You should specify in the written standards which organs you cover and any special conditions or limitations which apply to them.

B. Standards for Coverage.—If you choose to cover organ transplant procedures, furnish written standards for the coverage of these procedures which provide that:

- o similarly situated individuals are treated alike;
- o any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; and
- o services are reasonable in amount, duration, and scope to achieve their purpose.

1. Similarly Situated Individuals.—Similarly situated does not mean that anyone with end-stage organ disease, regardless of the etiology, must be covered. Apply transplant criteria fairly and uniformly to all individuals eligible for Medicaid. There is no justification for approving payment for a particular transplant procedure for one eligible recipient and denying payment for that same procedure for another similarly situated eligible recipient needing the same transplant procedure. You may, however, place limitations on coverage. For example, you can choose to cover transplants for the categorically needy, and not cover them for the medically needy. You can also choose to limit coverage to certain clinical conditions or to reasonable patient selection criteria. However, include these conditions in your standards. Do not list general statements such as "coverage is limited to those conditions for which the safety and efficacy of the transplant have been established," or "coverage is limited to nonexperimental procedures," as coverage standards.

2. Facility and Practitioner Restrictions.—In view of the extraordinary expense and complexity of transplant procedures, you can decide to commit your resources only to those facilities and practitioners of demonstrated excellence with regard to a particular procedure, whether located in your State or not. If you choose to restrict the facilities or practitioners, assure that the designated providers render high quality care and that they are accessible, through transportation arrangements made or paid for by the State, to all eligible Medicaid recipients throughout the State.

3. Sufficiency of Services.—Under regulations at 42 CFR 440.230, you are prohibited from "arbitrary" denial or reduction of an eligible recipient's benefits, but you are permitted to place appropriate limits based on medical necessity. You may cover transplants up to a dollar or day limit, and may refuse to continue coverage beyond such limits, even if the patient is currently in a transplant program. However, any limits applicable to transplants, whether in terms of dollars or days, should be reasonably related to the dollars or days necessary to cover the particular type of transplant for most transplant patients in the Medicaid-eligible population. For example, if the average hospital stay for a type of transplant is 30 days, a limit of 14 days would not be considered reasonable, even though such a limit might be acceptable for nontransplant patients. By the same token, you may provide additional coverage for transplant patients above normal State plan limits, and this would not constitute an arbitrary denial or reduction in services for other (nontransplant) recipient groups.

STATE PLAN UNDER, TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Kansas**Kansas Medical Assistance Program (KMAP),
MCO, PCCM and enhanced PCCM programs

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Kansas Medical Assistance Program (KMAP). All Medicaid beneficiaries as described in Section C are required to enroll in either a managed care organization (MCO), or a primary care case management (PCCM) program. The enhanced PCCM program is an enhanced primary care case management program in which Kansas PCCM Primary Care Physicians (PCPs) have an administrative entity assisting with case management. The administrative entity has developed care management and disease management strategies targeted to their respective populations. The PCPs receive the standard management fee and all providers are paid on a fee-for-service basis. The administrative entity receives an additional administrative management fee for the enhanced services. Section E target groups are not subject to mandatory enrollment but can voluntarily enroll.
2. The objectives of these programs are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.
3. This MCO program is intended to enroll Medicaid recipients in MCOs, which will provide or authorize all primary care services and all necessary specialty services, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The MCO/PCCM assigned practitioner will act as the PCP. The PCP and enhanced PCCM are responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under these programs.
4. The PCP and enhanced PCCM will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PCP and enhanced PCCM will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program. In the PCCM program, the PCP will receive a per member per month payment for case management services.
5. The enhanced PCCM entity will receive a per enrollee per month payment for enhanced case management services.
6. Recipients enrolled under this program will be restricted to receive covered services from the PCP or upon referral and authorization of the PCP or MCO. The PCP will manage the recipient's health care delivery. The KMAP program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM and enhanced PCCM programs. Recipients will have a minimum of 15 days to make the selection but may change the initial selection at any time. Enhanced PCCM exists in counties where the State has an administrative contract with an entity providing care management PCCM PCPs with care management. All individuals covered under this option who reside in these counties will be able to choose from among multiple Kansas PCCM PCPs.

7. Non-MCO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.
8. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO. Co-payments will apply for those services provided under the PCCM program.
9. The state requires recipients in PCCM and enhanced PCCM to obtain services only from their assigned PCP or through referral to a Medicaid-participating provider who provides such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.
10. PCCM may operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in a PCCM. The MCO and PCCM programs may operate in the same counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM program. Recipients will have the option to select from a PCCM PCP and MCO where available. The Medicaid recipient must choose one of these options for the delivery of health care services.
11. Public Process for proposed changes in the Kansas Medical Assistance Program (KMAP) MCO and PCCM and enhanced PCCM programs. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act for proposed changes in KMAP programs. Public notice will be published in the Kansas Register which is available to the public on a weekly basis.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.
2. The KMAP program is available in selected counties in Kansas. Mandatory enrollment provisions will not be implemented unless a choice of at least two PCCM PCPs or a combination of MCO and the PCCM and enhanced PCCM program is available.
3. Kansas has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.
4. Kansas will monitor and oversee the operation of the mandatory/voluntary managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.
5. Kansas will evaluate compliance by review and analysis of reports prepared and sent to the Kansas Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Kansas Medicaid agency.

6. Reports from the grievance and appeal process will be analyzed and used for evaluation purposes.
7. Kansas staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.
8. Kansas staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients for Mandatory Enrollment

The KMAP program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.
2. Aged, Blind and Disabled Adults (SSI).

D. Mandatory Enrollment Exclusions

1. The following groups will not be mandatorily enrolled in managed care:
 - a. Clients with Medicare coverage
 - b. Clients residing in nursing facilities and receiving custodial care
 - c. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR)
 - d. Clients who are residing out of state (ie. Children placed with relatives out of state, and who are designated as such by HHSS personnel);
 - e. Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program
 - f. Aliens who are eligible for Medicaid for an emergency condition only
 - g. Clients participating in the refugee resettlement program.

- h. Clients receiving services through the following home and community based waivers:
 - 1. Persons with mental retardation or developmental disabilities
 - 2. Individuals from ages 16-64 with physical disabilities
 - 3. Technology assisted children
 - 4. Individuals with traumatic brain injury
 - 5. Frail and elderly individuals
 - 6. Children with severe and emotional disturbance
- i. Clients who have excess income (i.e. spenddown - met or unmet)
- j. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state
- k. Clients having other insurance
- l. Clients enrolled in another Medicaid Managed Care Program
- m. Clients who have an eligibility program that is only retro-active.
- n. Clients under the custody of the Juvenile Justice Authority
- o. Clients residing in a State institution
- p. Clients designated as participants in the administrative lock in program.
- q. Indians who are members of Federally recognized tribes when the MCO or PCCM and enhanced PCCM is:
 - (i) The Indian Health Service; or
 - (ii) An Indian Health Program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with Indian Health Service.
- r. Children under 19 years of age who are:
 - (i) Eligible for SSI under Title XVI; or
 - (ii) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

E. Target Groups of Recipients for Voluntary Enrollment

The state must provide assurances that, in implementing the state plan managed care option, it will not require the following groups to enroll in an MCO or PCCM and enhanced PCCM:

- 1. Indians who are members of Federally recognized tribes, except when the MCO or PCCM and enhanced PCCM is:
 - a. The Indian Health Service; or
 - b. An Indian Health Program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

2. Children under 19 years of age who are:
 - a. Eligible for SSI under Title XVI; or
 - b. Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

F. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two KMAP providers. This will be multiple PCCM providers or a combination of PCCM providers and an MCO option or a choice of MCOs if two or more are available in a county. If a recipient has a prior provider relationship they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

Kansas contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

- a. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees. (EQRO performs this function).
- b. Answer KMAP-related questions from recipients and providers.
- c. Prepare enrollment materials for KMAP program, for Department approval, and store KMAP materials (MCO, PCCM and KMAP in general).
- d. Process new enrollments and transfers for those KMAP eligibles identified by the Department.
- e. Process the recipient's choice and assign to the provider. (PCCM and enhanced PCCM only receives a monthly card).
- f. Log grievances and requests for special authorization from KMAP enrollees.
- g. Perform various quality assurance activities for the KMAP program. This is inclusive of the QAT process.
- h. Supply an enrollment packet to the recipients that includes MCO and PCCM materials and information supplied by the state and plans.
- i. Enrollees who select the PCCM option are then eligible for enhanced PCCM where available. The state will utilize a software package to identify high risk enrollees. The identified enrollees will be listed on a roster and provided to the enhanced PCCM contractor. The enhanced PCCM contractor will invite the enrollees to participate in the enhanced PCCM program. Enhanced PCCM information will be provided by the ASO after approval by the state and selected by the enrollee.
- j. Provides enrollment counseling which includes:
 1. Inquiring about patient/provider experience and preference.
 2. Providing information on which MCOs or PCCM PCPs are available to maintain a prior patient-provider relationship.

3. Facilitating direct contact with individual PCPs, PCCM and enhanced PCCMs and MCOs, as necessary.
4. Providing any information and education concerning the enrollment process, individuals', benefits offered, the enrollment packet, client rights' and responsibilities and any of the other information provided for in this section.
2. If the mandatory recipient fails to choose an MCO or PCCM PCP within a minimum of 15 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCP in a PCCM or to a MCO. Kansas enrollment system can identify the voluntary recipients from data available to the system and will insure that these populations are not autoassigned. If a voluntary recipient does not choose to enroll with the PCCM or MCO, they will receive services on a fee-for-service basis.
3. Mandatory default enrollment will be based upon maintaining prior provider-patient relationships, proximity and prior familial/provider relationships or, where this is not possible, on maintaining an equitable distribution among managed care entities.
4. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).
5. Any selection or assignment of an PCP, MCO or PCCM and enhanced PCCM may be changed at any time.
6. PCPs, MCOs and PCCM and enhanced PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.
7. The MCO and PCCM and enhanced PCCMs will not terminate enrollment because of an adverse change in the recipient's health.
8. An enrollee who is terminated from an MCO or PCCM and enhanced PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM and enhanced PCCM upon regaining eligibility to the extent possible.
9. The recipient will be informed at the time of enrollment of the right to disenroll.
10. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO.
11. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

12. A general explanation of terms regarding enrollment and disenrollments (lock-in and referrals).
13. A description of the delivery system.
14. The responsibilities of the providers.
15. Enrollment procedures.
16. Provide information on services outside the MCO contract including the access to emergency services.

G. Process for Enrollment in an MCO/PCCM and enhanced PCCM

The following process is in effect for recipient enrollment in the KMAP Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among Managed Care Entities (MCEs) regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).
2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated into Spanish and other languages upon request, including Braille.
3. Recipients will be able to select an MCO or PCCM from a list of available managed care entities in their service area. If the recipient wishes to remain with a PCP or plan with whom a patient/physician relationship is already established, the recipient is allowed to do so to the extent possible. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection for the mandatory population is not made within the 15 day period describe above, the Medicaid program shall assign a MCO or PCCM and enhanced PCCM in accordance with the procedures outlined in F above.
4. The MCO and PCCM and enhanced PCCM will be informed electronically or in writing of the recipient's enrollment in that plan.
5. The recipient will be notified of enrollment and issued an identification card.
6. Additionally, each MCO will provide recipients the following information as soon as practical after activation of enrollment:
 - a. Benefits offered, the amount, duration, and scope of benefits and services available.
 - b. Procedures for obtaining services.

- c. Names and locations of current network providers, including providers that are not accepting new patients.
- d. Any restrictions on freedom of choice.
- e. The extent to which there are any restrictions concerning out-of-network providers.
- f. Policies for specialty care and services not furnished by the primary care providers.
- g. Grievance and appeal process.
- h. Member rights and responsibilities.

H. Maximum Payments

The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with generally accepted actuarial principles and practices as required by 42 CFR 438.6(c). State payments to contractors will comply with actuarial soundness in 42 CFR 438.6(c).

I. Covered Services

1. Services not covered by the KMAP program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the KMAP Program and the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with MCOs and PCCM and enhanced PCCMs and is specific to the service type and service provider.
2. MCOs are encouraged to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics and Indian Health Clinics.
3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the KMAP Program. "Emergency services" are defined in the MCO contract.
4. The PCCM shall be responsible for managing the services marked below in column (7). The MCO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by Medicaid fee-for-service (without referral).

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Not Required or Non-Waiver Services (7)
Service Category Capitated Svcs or PCCM referrals req. a referral:					
Inpt. Hospital	X	X			X
Non-psych	X	X			
Profess./clinic & other lab/x-ray	X	X			
Outpat. Hosp-lab & x-ray	X	X			
Outpt. Hosp - All other	X	X			
Maternity/Delivery Services	X	X			X if beneficiary PCCM is OB
Pharmacy/ Prescription Drugs	X	X			
Home Care & Hospice Services	X	X			X
Transportation - Ambulance & Emergency	X	X			X
Transportation - Other Medical and non-emergency	X	X			X

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Required (7)
Medical Supplies/DME	X	X			X
Vision Care	X	X			
FFS Wrap-Around Svcs. provided to waiver members and controlled by MCO or affected by PCCM					
Inpatient Hospital – Psych	X		X		X
Inpatient Hosp-heart, liver & bone marrow transplant	X		X		X
Psychiatrist	X		X		X
Family Planning	X	X			
Sterilization	X		X		
Abortion	X		X		
Psychologist	X				X
Prescription drugs - Psychiatric	X	X			
Prescription drugs - Family Planning	X	X			
Prescription drugs – Factor VIII	X		X		
Dental	X				
Mental Health - State Psychi. Hospital	X				
Mental Health – Nursing Facility	X				

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Required (7)
Mental Health – CMHC	X		X		X
Mental Health - Non CMHC	X		X		X
Mental Health - Behavior Management	X		X		X
Alcohol & Drug Addiction Treatment	X		X		X
Education Agency Services	X				

J. Mandate

1. In the KMAP program, Kansas will enter into contracts with State licensed MCOs. Kansas will enter into comprehensive risk contracts with the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services (excluding abortions and sterilizations not after delivery), RHC, and FQHC except for those described in Section H.1.

All contracts will comply with Sections 1932 and 1903(m) of the Act. Kansas has used and will continue to use a competitive procurement process. The Department sets the capitation rates by region in the state and any participating MCO must accept those rates for the respective Medicaid covered services.

2. With respect to the PCCM, the contracts Kansas enters into with PCPs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a \$2.00 monthly case management fee for each PCCM recipient assigned except for those recipients assigned to FQHCs and RHCs. The following is a list of the types of providers that qualify to be primary care providers under the KMAP program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists physician assistants), and certified nurse practitioners, certified nurse midwives, IHS, FQHCs, and RHCs.
3. The enhanced PCCM entity will receive a per enrollee per month administrative payment for enhanced case management services.

4. All participating PCPs in the PCCM shall be required to sign a PCCM participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCP shall be required to specify the number of recipients the PCP is willing to serve as a primary care case manager. Unless circumstances exist which require the Department to authorize a higher quota for a PCP to ensure adequate coverage in an area, the maximum shall be 1,800 recipients per primary care physician.
5. PCP under the KMAP program must:
 - a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;
 - b. If participating in a PCCM, sign a contract or addendum for enrollment as a PCP which explains the PCPs responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.
 - c. Provide or arrange for the provision of comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the PCP's practice;
 - d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;
 - e. Have hours of operations that are reasonable and adequate. The Department requires all PCPs to have 24-hour access via telephone. This does allow for another provider to be on-call for the PCP provider during non-office hours.
 - f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;
 - g. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;
 - h. Assign clients in the order in which they enroll.

6. Qualifications and requirements for PCPs are noted in the provider agreements. MCOs and PCCM and enhanced PCCMs shall meet all of the following requirements as applicable:
- a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.
 - b. The MCO shall sign a contract that explains the responsibilities in which the MCOs must comply.
 - c. The MCO shall have a state-approved grievance and appeal process.
 - d. The MCO or PCP shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO or PCCM Program.
 - e. The MCO or PCCM and enhanced PCCM PCP shall refer enrollees for specialty care, hospital care, or other services when medically necessary.
 - f. The MCO or PCCM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative or a representative of the PCCM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.
 - g. The MCO or PCCM and enhanced PCCM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.
 - h. The MCO or PCCM or enhanced PCCM may request reassignment of the participant to another MCO or PCCM or enhanced PCCM only with the approval of the state. Disenrollment may be allowed in certain situations, such as: abusive behavior; PCCM or enhanced PCCM, or MCO left the program; or noncompliance with medical orders.

The Department reviews all reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker and MCO as needed to review all current issues, including any requests for disenrollment by any PCCM or MCO.

- i. All MCO and PCCM and enhanced PCCM subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.
- j. The MCO shall be licensed by the Kansas Department of Insurance in order to ensure financial stability (solvency) and compliance with regulations.
- k. Access to medically necessary emergency services shall not be restricted as set forth in the prudent layperson guidelines (Section 1932(b)(2) of the Act). "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 (i) 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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.
- l. Kansas ensures enrollee access to emergency services by requiring the MCO or PCCM and enhanced PCCM to provide adequate information to all enrollees regarding emergency service access.
- m. Kansas ensures enrollee access to emergency services by including in the contract requirements for MCOs or PCCMs to cover the following:
 - 1. The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,
 - 2. The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,
 - 3. Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

4. Continued emergency services until the enrollee can be safely discharged or transferred,
5. Post-stabilization services that are pre-authorized by the MCO or primary care case manager, or were not pre-authorized, but the MCO or the primary care case manager failed to respond to a request for pre-authorization within one hour, or could not be contacted (Medicare+choice guidelines). Post-stabilization services remain covered until, the MCO or primary care case manager contacts the emergency room and takes responsibility for the enrollee.

K. Additional Requirements

1. Any marketing materials available for distribution under the Social Security Act, state statutes and regulations shall be provided to the Department for its review and approval.
2. The MCO shall certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services Kansas Medicaid will not pay for.
3. The MCO shall include safeguards against fraud and abuse, as provided in state statutes.

L. IHS, FQHC and RHC Services

The program is voluntary and the enrollee is guaranteed a choice of either an FQHC as a PCP, a PCP that contracts with an FQHC, or at least one MCO/PCCM which has at least one FQHC as a participating provider.

All of the FQHCs in the state are participating in the PCCM program. This allows any recipient to be able to select a PCP employed or contracted with an FQHC as the primary care case manager. In addition, the MCO contract specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The MCOs must pay FQHCs and RHCs rates comparable to non-FQHC and non-RHC providers. Kansas State Medicaid Plan provides for the prospective payments to FQHCs and RHCs.

The enrollee is guaranteed access a choice of either an RHC or IHS as a PCP, a PCP that contracts with an RHC or IHS, or at least one MCO/PCCM which has at least one RHC or IHS as a participating provider.

M. Quality of Health Care and Services, Including Access

1. Kansas requires all MCOs and providers, by contract, to meet state-specified standards for internal quality assurance programs (QAPs).

2. On a periodic or continuous basis, Kansas monitors the adherence to these standards by all MCOs, through the following mechanisms:
 - a. Review of the written QAP for each MCO to monitor adherence to the Kansas QAP standards. Such review shall take place at least annually.
 - b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the MCO.
 - c. Monitoring of the implementation of the QAP to ensure compliance with Kansas QAP standards. This monitoring is conducted on-site at the MCO administrative offices as necessary. At least one such monitoring visit shall occur per year through the use of departmental staff and contract staff.
3. The Department will arrange for an independent, external review of the quality of services delivered under each MCO's contract with the state. The review will be conducted for each MCO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an MCO, or an association of any MCOs.
4. Recipient access to care will be monitored as part of each MCO's internal QAP and through the annual external quality review for MCOs. The periodic medical audits, state monitoring activities and the external quality review shall all derive the following information:
 - a. A complete GEO access is completed annually. An exception mapping is completed the following 6 months.
 - b. CAHPS (Consumer Assessment of Health Plan Survey) surveys managed by MCO staff.
 - c. A measurement of waiting periods to obtain health care services, including appointment accessibility based on standards for waiting time and monitor performance against these standards.
 - d. The EQRO submits to the Department a quarterly report analyzing the disenrollment from the KMAP.
 - e. The Grievance and appeal reports from the MCO will be reconciled and resolved.
 - f. Quality improvement projects regarding clinical areas of care including EPSDT.

N. Access to Care

Kansas assures that recipients will have a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM and enhanced PCCM program. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the KMAP program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs or PCCM PCPs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.
2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the KMAP Program.
3. Access standards for distances and travel miles to obtain services for recipients under the KMAP program have been established.

The Department utilizes 30 minutes for urban counties and 30 miles for all other areas in the MCO and PCCM programs. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. The Department will review each county for PCP access on a yearly basis in the MCO program.

The PCCM and enhanced PCCM option allows the PCP to give a referral to any Kansas Medicaid provider, thus the panel of specialists would be the entire Kansas Medicaid provider network. This allows any PCCM and enhanced PCCM enrollee to see any specialist that accepts Kansas Medicaid. Therefore, this network is no less than the network available to a person not in the KMAP program.

The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.
5. Pre-authorization is precluded for emergency care and family planning services under the KMAP Program.
6. Recipients have the right to change plans at any time.

7. Voluntary populations remain in FFS unless they choose to enroll in Managed Care. Once enrolled in managed care, a voluntary population recipient can disenroll at anytime to be effective the 1st day of the 2nd month following the month in which the enrollee requests disenrollment.
8. MCOs and PCCM PCPs are required to provide or arrange for coverage 24 hours a day, 7 days a week.
9. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.
10. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the KMAP program.
11. Kansas assures that state-determined access standards are maintained.
12. Under the terms and conditions of their existing contracts, MCOs must:
 - a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.
 - b. Provide to enrollees and prospective enrollees: an informational letter written in the applicable language explaining the MCO policies, a toll-free number to obtain further information about the MCO in the applicable language, and translation services when necessary to ensure delivery of covered services.
 - c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the MCO is aware of any such provider
13. Emergency services are available at all times to members who appropriately seek emergency care under the "prudent lay person" definition of emergency care. (Section 1932(b)(2) of the Act).
14. Emergent primary care provider appointments are available the same day, seven days per week, twenty-four hours per day, (e.g., high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services).
15. Routine care appointments are available within 45 days (e.g., well child exams, routine physical exams).
16. For specialty referrals, arrangements and provisions, the Contractor shall be able to provide:
 - a. Emergent specialty care appointments, arrangements and provisions within twenty-four (24) hours of referral.
 - b. Urgent specialty care appointments available within three days of referral.
17. Kansas has a limit of (1,800) on the number of recipients that can be managed by a PCP in the PCCM program.

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

1937(a),
1937(b)

X / The State elects to provide alternative benefits under Section
1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following
populations:

a. / Required Populations who are full benefit eligible
individuals in a category established on or before February
8, 2006, will be required to enroll in an alternative benefit
package to obtain medical assistance except if within a
statutory category of individuals exempted from such a
requirement.

List the population(s) subject to mandatory alternative
coverage:

b. X / Opt-In Populations who will be offered opt-in
alternative coverage and who will be informed of the
available benefit options prior to having the option to
voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in
alternative coverage:

TWWIA Basic - 1902(a)(10)(A)(ii)(XV)

Individuals categorically eligible as "TWWIA Basic" (individuals eligible for the
Kansas Medicaid Buy-In program, *Working Healthy*) with developmental disabilities,
physical disabilities, and traumatic brain injuries, who require personal assistance
services.

For the opt-in populations/individuals, describe the manner
in which the State will inform each individual that such

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enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

Individuals who meet eligibility requirements will be notified by their eligibility worker via a letter, and informed that a *Working Healthy* Benefits Specialist is available to discuss options available to them as employed individuals who need personal assistance and related services in order to live and work in the community. Benefits Specialists, will inform potential participants that enrollment in *Working Healthy*, and accessing personal assistance and related services (assistive services and independent living counseling) through the Alternative Benefits – Benchmark Benefit Package, is optional and that may continue to live and work in the community and access personal assistance and related services. Benefits Specialists are also available to review the advantages and disadvantages of each option in order to assist individuals in making an informed choice.

Benefits Specialists will also be available to help individuals to dis-enroll and to assist them in resuming access to personal assistance and related services.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

1. Assessment – A person centered evaluation to determine the need, strengths, and preferences of the individual for personal assistance and related services, as well as the amount of personal assistance and related services required.
2. Personal Assistance Services - One or more persons assisting a person with a disability with tasks that the disabled individual would typically do for him/herself in the absence of a disability. Such tasks can be related to personal needs as well as community and work-related needs, and assistance may be performed at home, in the community, or at work. Such services may include assisting the consumer in accomplishing any Activity of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs). Personal Assistance Services also includes alternative and/or cost-effective methods of obtaining assistance that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance, e.g., a microwave oven, sending out laundry, etc

ADLs include bathing, grooming, toileting, transferring, feeding, mobility. Health maintenance activities may be provided in accordance with K.S.A. 65-6201 as attached, and are documented in a written service plan.

IADLs include shopping, housecleaning, meal preparation, and laundry.

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Participants may self-direct their care, or may choose a representative to direct their care on their behalf. Participants receiving Personal Assistance Services may not reside in a home or property that is owned, operated, or controlled by a provider of services not related by blood or marriage.

The written services plan will be based on the assessment. The written services plan will be developed in a person centered process and will include the services, and supports for those services, as prescribed by the assessment. The written service plan will also include an emergency back-up plan. The written service plan will build upon the individual's capacity to engage in activities that promote community life and employment, and respect the individual's preferences, choices, and abilities. The written service plan development will involve family, friends, and professionals, as desired by the participant. The need for personal assistance services must be documented in the written service plan. The written service plan must be approved by Medicaid staff.

The amount of funds allocated for a participant's written services plan will be based on the assessment and the written service plan. A methodology will be used to determine the amount of funds allocated based on valid and reliable cost data, will be open to public inspection, and will include a calculation of the cost of the services if they were not self-directed.

Once funds are allocated, a service budget will be developed by the participant and any other people the participant wants to include in the process. The service budget must be approved by Medicaid staff.

Participants will be permitted to manage the funds budgeted to purchase Personal Assistance Services. Participants may personally manage their own funds after demonstrating an ability to do so, or they may choose a fiscal management service to manage their funds on their behalf.

The State elects to disburse cash prospectively to participants self-directing personal assistance and related services.

3. Independent Living Counseling – Independent Living Counseling includes one or more of the following:

- orientation;
- training in self-direction;
- fiscal management training;
- assistance in accessing other systems that will enhance independent living and/or employment;

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- assistance in developing the written service plan and service budget;
- assistance in locating fiscal management services;
- assistance in locating, interviewing, hiring, supervising, and terminating a personal attendant;
- assistance in locating emergency back-up care and emergency assistance;
- assistance in reporting exploitation and/or emotional and/or physical abuse to SRS Adult Protective Services;
- assistance in locating and maintaining services identified in the service plan;
- assistance with dis-enrolling and accessing waiver and/or other services;

The need for independent living counseling services must be documented in the written service plan.

4. Assistive Services – Assistive Services is defined as any item, piece of equipment, or environmental modification, which is used to increase, maintain, or improve independence, employment, and/or health and safety. Purchase or rent of new or used assistive technology is limited to those items not covered by Medicaid under the State Plan. Examples include, but are not limited to, ramps, lifts, modifications to bathrooms and kitchens specifically related to accessibility, and assistive technology that improves communication and/or mobility in the home and work place. Assistive Services also includes any service that directly assists an individual with a disability in the selection, acquisition, or use of assistive technology.

The need for assistive services must be documented in the written service plan.

5. Kansas Medicaid State Plan Services

c. X / Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

Statewide _____

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

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STATE FLEXIBILITY IN BENEFIT PACKAGES

ELIGIBLE POPULATIONS (OPTIONAL)	GEOGRAPHIC LOCATION	SERVICES
TWWIA Basic - 1902(a)(10)(A)(ii)(XV) who have either developmental disabilities, physical disabilities, or traumatic brain injury who require personal assistance services	STATEWIDE	<ul style="list-style-type: none"> ▪ Assessment ▪ Personal Assistance Services ▪ Independent Living Counseling ▪ Assistive Services ▪ Medicaid State Plan Services

B. Description of the Benefits

 X / The State will provide the following alternative benefit packages (check all that apply).

1937(b) 1.

1. X / Benchmark Benefits

a. / **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

b. / **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State’s employee benefits plan package.

c. / **Coverage Offered Through a Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO’s benefit package.

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d. X / **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

Following are services provided under the Benchmark Benefits/Secretary-approved coverage that are the same as offered under the Medicaid State Plan:

Inpatient Hospital Services Limitations
 Outpatient Hospital Services Limitations
 Rural Health Clinic Services
 Limitations of Federally Qualified Health Centers
 Other Laboratory and X-ray services limitations
 Kan Be Healthy (Early and Periodic Screening and
 Diagnosis and Treatment) Limitations
 Family Planning Services Limitations
 Physicians' Services Limitations
 Dental Services Limitations
 Optometric Services Limitations
 Other Practitioners' Services Limitations
 Home Health Services
 Home Health Nursing Limitations
 Home Health Aide Services
 Home Health Services DME
 Limitations of Physical Therapy, Occupational Therapy,
 Speech Language Pathology and Restorative Aide Services
 provided by a Home Health Agency
 Clinic Services Limitations
 Physical Therapy Services
 Occupational Therapy Services
 Speech, Hearing and Language Services Limitations
 Prescribed Drugs Limitations
 Dentures Limitations
 Prosthetic Devices
 Eyeglasses Limitations
 Rehabilitation Services Limitations
 Services for Individuals Age 65 or Older in Institutions for
 Mental Diseases
 Inpatient Hospital Services Limitations
 Limitations for Services for Individuals Age 65 or Older in
 Institutions for Mental Diseases, Intermediate Care
 Facilities

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Inpatient Psychiatric Facility Services for Individuals
Under 22 Years of Age Limitations
Nurse-Midwife Services Limitations
Hospice Services Limitations
Limitations of Extended Services to Pregnant Women
Limitations of Pediatric or Family Nurse Practitioners'
Services
Transportation Limitations
Skilled Nursing Facility Services for Patients Under 21
years
Limitations of personal care services in a recipient's home,
prescribed in accordance with a plan of treatment and
provided by a qualified person under the supervision of a
registered nurse Case Management Services

In addition to the above state plan services the benchmark
plan will include assessment, personal assistance services,
independent living counseling and assistive services, as
defined on pages 2 thru 4.

2. ___/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit
package is equivalent to, and provide the information listed
above for that plan: _____.

a. ___/ The State assures that the benefit package(s) have been
determined to have an actuarial value equivalent to the
specified benchmark plan or plans in an actuarial report that: 1)
has been prepared by an individual who is a member of the
American Academy of Actuaries; 2) using generally accepted
actuarial principles and methodologies; 3) using a standardized
set of utilization and price factors; 4) using a standardized
population that is representative of the population being served;
5) applying the same principles and factors in comparing the
value of different coverage (or categories of services) without
taking into account any differences in coverage based on the
method of delivery or means of cost control or utilization used;
and 6) takes into account the ability of a State to reduce
benefits by taking into account the increase in actuarial value
of benefits coverage without taking into account any
differences in coverage based on the method of delivery or
means of cost control or utilization used and taking into
account the ability of the State to reduce benefits by
considering the increase in actuarial value of health benefits
coverage offered under the State plan that results from the

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limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. ___ / The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. ___ / The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) ___ / **Inclusion of Basic Services** – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

___ / Inpatient and outpatient hospital services;

___ / Physicians' surgical and medical services;

___ / Laboratory and x-ray services;

___ / Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices

___ / Other appropriate preventive services, as designated by the Secretary.

___ / Clinic services (including health center services) and other ambulatory health care services.

___ / Federally qualified health care services

___ / Rural health clinic services

___ / Prescription drugs

___ / Over-the-counter medications

___ / Prenatal care and pre-pregnancy family services and supplies

___ / Inpatient Mental Health Services not to exceed 30 days in a calendar year

___ / Outpatient mental health services furnished in a

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State-operated facility and including community based services

/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices

/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.

/ Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year

/ Dental services

/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year

/ Outpatient substance abuse treatment services

/ Case management services

/ Care coordination services

/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.

/ Premiums for private health care insurance coverage

/ Medical transportation

/ Enabling services (such as transportation, translation, and outreach services

/ Any other health care services or items specified by the Secretary and not included under this section

(2) Additional benefits for voluntary opt-in populations:

/ Home and community-based health care services

/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

3. Wrap-around/Additional Services

a. / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and

treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

b. / The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

The State assures it will provide an effective quality assurance and improvement system that incorporates performance of discovery, remediation and quality improvement activities. The State agrees to comply with future state plan quality requirements that CMS may issue.

Check all that apply.

1. / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
2. / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).
3. / The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.
4. / Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

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5. / Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

1. Enrollment – The Department of Social and Rehabilitation Services (SRS) eligibility staff will determine eligibility.
2. Benefits Planning - SRS Benefits Specialists will provide information about this and other options to help them make an informed choice.
3. Assessment – The Kansas Health Policy Authority (KHPA) will contract with an agency to provide assessments and re-determinations.
4. Written Services Plan, Allocation, Service Budget - The written services plan will be developed by KHPA staff in conjunction with participants and anyone they wish to include in the process, including an Independent Living Counselor. The amount of funds allocated for a participant's written services plan will be determined by KHPA staff and based on the assessment and the written service plan. A service budget will be developed by the participant and any other people the participant wants to include in the process. The service budget must be approved by KHPA staff.
5. Independent Living Counseling – Independent Living Counseling will be provided by staff of community based organizations that contract with KHPA as Medicaid providers.
6. Fiscal Management Services – Fiscal Management Services may be provided by community organizations providing these services for HCBS participants, or traditional agencies such as accounting firms who contract with KHPA as Medicaid providers. Participants also have the option of acting as their own fiscal manager if they elect the cash option.

D. Additional Assurances

a. X / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. X / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

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Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

X / The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

X / The State will implement this State Plan amendment on 01/01/07.

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ATTACHMENT 3.2-A

Coordination of Title XIX WITH Part B of Title XVIII

Revision: HCFA-PM-87-4
MARCH 1987

(BERC)

ATTACHMENT 3.2-A
OMB No. : 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

CONDITION OF TITLE XIX WITH PART B OF TITLE XVIII

=====
The following method is used to provide the entire range of benefits under Part B of Title XVIII to the groups of Medicare-eligible individuals indicated:

- A. Buy-in agreements with the Secretary of HHS. This agreement covers:
1. Individuals receiving SSI under Title XVI or State supplementation, who are categorically needy under the State's approved Title XIX plan.

Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:
 Yes No
 2. Individuals receiving SSI under Title XVI, State supplementation, or a money payment under the State's approved Title IV-A plan, who are categorically needy under the State's approved Title XIX plan.

Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:
 Yes No
 3. All individuals eligible under the State's approved Title XIX plan.
- B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:
- C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups: All individuals for whom Buy-In premiums are paid.

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. ...if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g., does #1 for money payment receipts and #3 for non-\$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

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