DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #06-13

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1937 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 $ 90,450
b. FFY 2008 $1,956,240

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-G, Pages 1-~~10~~ 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Benchmark Benefit Package

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Marcia Nielsen, PhD, MPH is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature] for

13. TYPED NAME:
Marcia Nielsen, PhD, MPH

14. TITLE:
Interim Executive Director of the Kansas Health Policy Authority

15. DATE SUBMITTED:

16. RETURN TO:
Marcia Nielsen, PhD, MPH
Kansas Health Policy Authority
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 24, 2006

18. DATE APPROVED: September 7, 2006

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2007

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health

23. REMARKS:
per email from state

FORM HCFA-179 (07-92)

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:
TWWIIA Basic - 1902(a)(10)(A)(ii)(XV)

Individuals categorically eligible as "TWWIIA 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

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.

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;

- 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.

STATE FLEXIBILITY IN BENEFIT PACKAGES

ELIGIBILE POPULATIONS (OPTIONAL)	GEOGRAPHIC LOCATION	SERVICES
TWWIIA Basic - 1902(a)(10)(A)(ii)(XV) who have either developmental disabilities, physical disabilities, or traumatic brain injury who require personal assistance services	STATEWIDE	▪ 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.

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

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

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

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. _X_ / 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. _X_/ 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.

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

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.